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Appendix A METHODOLOGY

1. Introduction

This version of the Standards of Care (SOC-8) is based upon a more rigorous and methodological evidence-based approach than previous versions. This evidence is not only based on the published literature (direct as well as background evidence) but also on consensus-based expert opinion. Evidence-based guidelines include recommendations intended to optimize patient care and are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. Evidence-based research provides the basis for sound clinical practice guidelines and recommendations but must be balanced by the realities and feasibility of providing care in diverse settings. The process for development of the SOC-8 incorporated recommendations on clinical practice guideline development from the National Academies of Medicine and The World Health Organization that addressed transparency, the conflict-of-interest policy, committee composition and group process. (Institute of Medicine Committee on Standards for Developing Trustworthy Clinical Practice, 2011; World Health Organization, 2019a).

The SOC-8 revision committee was multidisciplinary and consisted of subject matter experts, health care professionals, researchers and stakeholders with diverse perspectives and geographic representation. All committee members completed conflict of interest declarations.*

A guideline methodologist assisted with the planning and development of questions, and an independent team undertook systematic reviews that were used to inform some of the statements for recommendations. Additional input to the guidelines was provided by an international advisory committee, legal experts, and feedback received during a public comment period. Recommendations in the SOC-8 are based on available evidence supporting interventions, a discussion of risks and harms, as well as feasibility and acceptability within different contexts and country settings. Consensus of the final recommendations was attained using a Delphi process that included all members of the Standards of Care Revision committee and required that recommendation statements were approved by 75% of members. Supportive and explanatory text of the evidence for the statements were written by chapter members. Drafts of the chapters were reviewed by the Chair and the Co-Chairs of the SOC Revision Committee to ensure the format was consistent, evidence was properly provided, and recommendations were consistent across chapters. An independent team checked the references used in the SOC-8 before the guidelines were fully edited by a single professional. A detailed overview of the SOC-8 Methodology is described below.

2. Difference between the methodology of the SOC-8 and previous editions

The main differences in the methodology of the SOC-8 when compared with other versions of the SOC are:

- The involvement of a larger group of professionals from around the globe;
- A transparent selection process to develop the guidelines steering committee as well as to select chapter leads and members;
- The inclusion of diverse stakeholders in the development of the SOC-8
- Management of conflicts of interest
- The use of a Delphi process to reach agreement on the recommendations among SOC-8 committee members
- The involvement of an independent body from a reputable university to help develop the methodology and undertake independent systematic literature reviews where possible
- Recommendations were graded as either "recommend" or "suggest" based upon the strength of the recommendations.
- The involvement of an independent group of clinical academics to review citations.
- The involvement of international organizations working with the transgender and gender diverse (TGD) community, members of WPATH and other professional organizations as well as the general public who provided feedback through a public comment period regarding the whole SOC-8.

3. Overview of SOC-8 development Process

The steps for updating the Standards of Care are summarized below:

1. Establishing Guideline Steering Committee including Chair, and Co-Chairs (July 19, 2017)
2. Determining chapters (scope of guidelines)
3. Selecting Chapter Members based upon expertise (March 2018)
4. Selecting the Evidence Review Team: John Hopkins University (May 2018)
5. Refining topics included in the SOC-8 and review questions for systematic reviews
6. Conducting systematic reviews (March 2019)
7. Drafting the recommendation statements
8. Voting on the recommendation statements using a Delphi process (September 2019–February 2022)
9. Grading of the recommendations statements
10. Writing the text supporting the statements
11. Independently validating the references used in the supportive text
12. Finalizing a draft SOC-8 (December 1, 2021)
13. Feedback on the statements by International Advisory Committee
14. Feedback on the entire draft of the SOC-8 during a public comment period (November 2021–January 2022)
15. Revision of Final Draft based on comments (January 2022- May 2022)
16. Approval of final Draft by Chair and Co-Chairs (June 10, 2022)
17. Approval by the WPATH Board of Directors
18. Publication of the SOC-8
19. Dissemination and translation of the SOC-8

3.1. Establishment of Guideline Steering Committee

The WPATH Guideline Steering Committee oversaw the guideline development process for all chapters of the Standards of Care. Except for the Chair (Eli Coleman) who was appointed by the WPATH board to maintain a continuity from previous SOC editions, members of the Guideline Steering Committee were selected by the WPATH Board from WPATH members applying for these positions. Job descriptions were developed for the positions of Co-Chairs, Chapter Leads, Chapter Members and Stakeholder. WPATH members were eligible to apply by completing an application form and submitting their CV. The Board of WPATH voted for the position of co-chair (one member of the board did not participate in view of conflict of interest). The chairs and co-chairs selected the chapter leads and members (as well as stakeholders) based on the application form and CVs.

The Guideline Steering Committee for Standards of Care 8th Version are:

- Eli Coleman, PhD (Chair) Professor, Director and Academic Chair, Institute for Sexual and Gender Health, Department of Family Medicine and Community Health, University of Minnesota Medical School (USA)
- Asa Radix, MD, PhD, MPH (Co-chair) Senior Director, Research and Education Callen-Lorde Community Health Center Clinical Associate Professor of Medicine New York University, USA
- Jon Arcelus, MD, PhD (Co-chair) Professor of Mental Health and Well-being Honorary Consultant in Transgender Health University of Nottingham, UK
- Karen A. Robinson, PhD (Lead, Evidence Review Team) Professor of Medicine, Epidemiology and Health Policy & Management Johns Hopkins University, USA

3.2. Determination of topics for chapters

The Guideline Steering Committee determined the chapters for inclusion in the Standards of Care by reviewing the literature and by reviewing the previous edition of the SOC. The chapters in the Standards of Care 8th Version:

1. Terminology
2. Global Applicability
3. Population estimates
4. Education*
5. Assessment of Adults
6. Adolescent
7. Children
8. Nonbinary
9. Eunuch
10. Intersex
11. Institutional environments
12. Hormone Therapy
13. Surgery and Postoperative Care
14. Voice and communication
15. Primary care
16. Reproductive Health
17. Sexual Health
18. Mental Health

* The Education Chapter was originally intended to cover both education and ethics. A decision was made to create a separate committee to write a chapter on ethics. In the course of writing the chapter, it was later determined topic of ethics was best placed external to the SOC8 and required further in-depth examination of ethical considerations relevant to transgender health.

3.3. Selection of chapter members

A call for applications to be part of the SOC-8 review committee (chapter lead or member) was sent to the WPATH membership. The Chairs of the Guideline Steering Committee appointed the members for each chapter, ensuring representation from a variety of disciplines and perspectives.

Chapter Leads and Members were required to be WPATH Full Members in good standing and content experts in transgender health, including in at least one chapter topic. Chapter Leads reported to the Guideline Steering Committee and were responsible for coordinating the participation of Chapter Members. Chapter members reported directly to the Chapter Lead.

Each chapter also included stakeholders as members who bring perspectives of transgender health advocacy or work in the community, or as a member of a family that included a transgender child, sibling, partner, parent, etc. Stakeholders were not required to be full members of WPATH.

The Chapter Members were expected to:

- Participate in the development refinement of review questions
- Read and provide comments on all materials from the Evidence Review Team
- Critically review draft documents, including the draft evidence report
- Review and assess evidence and draft recommendations
- Participate in the Delphi consensus process
- Develop the text to back up the recommendation statements
- Grade each statement to describe the strength of the recommendation
- Review and address the comments from the Chairs during the whole process
- Develop the content of the chapters
- Review comments from public comments and assist in the development of a revision of guidelines
- Provide input and participate in the dissemination of guidelines

Training and orientation for Chapter Leads and Members was provided, as needed. Training content included formulation and refinement of questions (i.e., use of PICO), reviewing the evidence, developing recommendation state-

ments, grading the evidence and the recommendations, and information about the guideline development program and process.

A total of 26 chapter-leads were appointed (some chapters required co-leads), 77 chapter members and 16 stakeholders. A total of 127 were selected. During the SOC process, 8 people left, due to personal or work-related issues. Therefore, there were 119 final authors of the SOC-8.

3.4. Selection of the evidence review team

The WPATH Board issued a request for applications to become the Evidence Review Team. For Standards of Care 8th Version the WPATH Board engaged the Evidence Review Team at Johns Hopkins University under the leadership of Karen Robinson.

- Karen A. Robinson, PhD (Lead, Evidence Review Team) Professor of Medicine, Epidemiology and Health Policy & Management Johns Hopkins University, USA

Dr Robinson also guided the steering committee in the development of the SOC-8 by providing advice and training in the development of PICO questions, statements, and the Delphi process as well as undertaking a very rigorous systematic literature review where direct evidence was available.

Conflict of interest

Members of the Guideline Steering Committee, Chapter Leads and Members, and members of the Evidence Review Team were asked to disclose any conflicts of interest. Also reported, in addition to potential financial and competing interests or conflicts, are personal or direct reporting relationships with a chair, co-chair or a WPATH Board Member or the holding of a position on the WPATH Board of Directors.

3.5. Refinement of topics and review of questions

The Evidence Review Team abstracted the recommendation statements from the prior version of the Standards of Care. With input from the Evidence Review Team, the Guideline Steering Committee and Chapter Leads determined:

- Recommendation statements that needed to be updated
- New areas requiring recommendation statements

3.6. Conduct the systematic reviews

Chapter Members developed questions to help develop recommendation statements. For the questions eligible for systematic review, the Evidence Review Team drafted review questions, specifying the Population, Interventions, Comparisons, and Outcomes (PICO elements). The Evidence Review Team undertook the systematic reviews. The Evidence Review Team presented evidence tables and other results of the systematic reviews to the members of the relevant chapter for feedback.

Protocol

A separate detailed systematic review protocol was developed for each review question or topic, as appropriate. Each protocol was registered on PROSPERO.

Literature search

The Evidence Review Team developed a search strategy appropriate for each research question including MEDLINE®, Embase™, and the Cochrane Central Register of Controlled Trials (CENTRAL). The Evidence Review Team searched additional databases as deemed appropriate for the research question. The search strategy included MeSH and text terms and was not limited by language of publication or date.

The Evidence Review Team hand searched the reference lists of all included articles and recent, relevant systematic reviews. The Evidence Review Team searched ClinicalTrials.gov for any additional relevant studies.

Searches were updated during the peer review process.

The literature included in the systematic review was mostly based on quantitative studies conducted in Europe, the US or Australia. We acknowledge a bias towards perspectives from the global north that does not pay sufficient attention to the diversity of lived experiences and perspectives within transgender and gender diverse (TGD) communities across the world. This imbalance of visibility in the literature points to a research and practice gap that needs to be addressed by researchers and practitioners in the future in order to do justice to the support needs of all TGD people independent of gender identification.

Study selection

The Evidence Review Team, with input from the Chapter Workgroup Leads, defined the eligibility criteria for each research question *a priori*.

Two reviewers from the Evidence Review Team independently screened titles and abstracts and full-text articles for eligibility. To be excluded, both reviewers needed to agree that the study met at least one exclusion criteria. Reviewers resolved differences regarding eligibility through discussion.

Data extraction

The Evidence Review Team used standardized forms to abstract data on general study characteristics, participant characteristics, interventions, and outcome measures. One reviewer abstracted the data, and a second reviewer confirmed the abstracted data.

Assessment of risk of bias

Two reviewers from the Evidence Review Team independently assessed the risk of bias for each included study. For

randomized controlled trials, the Cochrane Risk of Bias Tool was used. For observational studies, the Risk of Bias in Non-Randomized Studies—of Interventions (ROBINS-I) tool was used. Where deemed appropriate, existing recent systematic reviews were considered and evaluated using ROBIS.

Data synthesis and analysis

The Evidence Review Team created evidence tables detailing the data abstracted from the included studies. The members of the Chapter Workgroups reviewed and provided comments on the evidence tables.

Grading of the evidence

The Evidence Review Team assigned evidence grades using the GRADE methodology. The strength of the evidence was obtained using predefined critical outcomes for each question and by assessing the limitations to individual study quality/risk of bias, consistency, directness, precision, and reporting bias.

3.7. Drafting of the Recommendation Statements

Chapter Leads and Members drafted recommendation statements. The statements were crafted to be feasible, actionable, and measurable.

Evidence-based recommendation statements were based on the results of the systematic, and background literature reviews plus consensus-based expert opinions.

The Chair and Co-Chairs and Chapter Leads reviewed and approved all recommendation statements for clarity and consistency in wording. During this review and throughout the process any overlap between chapters was also addressed.

Many chapters had to work closely together to ensure consistency of their recommendations. For example, as there are now separate chapters for childhood and adolescence, to ensure consistency between both chapters, some authors were part of both chapters. For a similar reason, when applicable, a workgroup collaborated with other Chapter Workgroups on topics shared between the chapters (i.e., Assessment of Children, Assessment of Adults, Hormone Therapy, Surgery and Postoperative Care and Reproductive Health).

3.8. Approval of the recommendations using the Delphi process

Formal consensus for all statements was obtained using the Delphi process (a structured solicitation of expert judgements in three rounds). For a recommendation to be approved, a minimum of 75% of the voters had to approve the statement. A minimum of 65% of the SOC-8 members had to take part in the Delphi process for each statement. People who did not approve the statement had to provide information as to the reasons for their disapproval, so the statement could be modified (or removed) according to this feedback. Once modified, the statement was put through the Delphi process again. If after 3 rounds the statement was not approved, the statement was removed from the SOC. Every member of the SOC voted for each statement. There was a response rate between (74.79% and 94.96%) for the statements.

3.9. Grading criteria for statements

Once the statements passed the Delphi process, chapter members graded each statement using a process adapted from the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) framework. This a transparent framework for developing and presenting summaries of evidence and provides a systematic approach for making clinical practice recommendations (Guyatt et al., 2011). The statements were graded based on factors such as:

- The balance of potential benefits and harms
- Confidence in that balance or quality of evidence
- Values and preferences of providers and patients
- Resource use and feasibility

The statements were classified as:

- Strong recommendations ("we recommend") are for those interventions/therapy/strategies where:
  - the evidence is of high quality
  - estimates of the effect of an intervention/therapy/strategy (i.e., there is a high degree of certainty effects will be achieved in practice)
  - there are few downsides of therapy/intervention/strategy
  - there is a high degree of acceptance among providers and patients or those for whom the recommendation applies.
- Weak recommendations ("we suggest") are for those interventions/therapy/strategies where:
  - there are weaknesses in the evidence base
  - there is a degree of doubt about the size of the effect that can be expected in practice
  - there is a need to balance the potential upsides and downsides of interventions/therapy/strategies
  - there are likely to be varying degrees of acceptance among providers and patients or those for whom the recommendation applies.

3.10. Writing of the text supporting the statements

Following the grading of the statements, the Chapter Workgroups wrote the text providing the rationale or reasoning for the recommendation. This included providing the available evidence, providing details about potential benefits and harms, describing uncertainties, and information about implementation of the recommendation, including expected barriers or challenges among others. References use APA-7 style, to support the information in the text. Links to resources are also provided, as appropriate. The text, including whether a recommendation has been described as strong or weak, was reviewed and approved by the Chair and Co-Chairs.

3.11. External validation of references used to support the statements

A group of independent clinical academics working in the field of transgender health reviewed the references used in every chapter in order to validate that the references were appropriately used to support the text. Any queries regarding the references were sent back to the chapters for review.

3.12. Finalizing a draft SOC-8

A final SOC-8 draft was made available for comments.

3.13. Distribute Standards of Care for review by international advisors

The statements of the recommendations of Standards of Care 8th were circulated among the broader Standards of Care Revision Committee and the WPATH International Advisory Group, which included the Asia Pacific Transgender Network (APTN), the Global Action for Transgender Equality (GATE), the International Lesbian, Gay, Bisexual, Transgender, Intersex Association (ILGA), and Transgender Europe (TGEU).

3.14. Public comment period

The revised draft version of the Standards of Care document was posted online for comment from the public, including WPATH members, on the WPATH website. A 6-week period was allocated for comments. A total of 1,279 people made comments on the draft with a total of 2,688 comments.

3.15. Revision of final draft based on comments

The Chapter Leads and Guideline Steering Committee considered the feedback and made any necessary revisions. All public comments were read and, where appropriate, integrated into the background text.

As part of this process, 3 new Delphi statements were developed and 2 were modified enough to require a new vote by the SOC-8 committee. This meant a new Delphi process was initiated in January 2022. The results of this Delphi process were accepted by the chapters, and the new statements were added or modified accordingly. The new supportive text was added.

All the new versions of the chapters were reviewed again by the Chair and Co-Chairs and changes or modifications were suggested. Finally, once the Chairs and the Chapter Members were satisfied with the draft, the chapter was finalized.

All new references were double checked by an independent member.

3.16. Approval of final draft by Chair and Co-Chairs

Modifications were reviewed by the Chairs and were accepted by them.

3.17. Approval by the WPATH Board of Directors

The final document was presented to the WPATH Board of Directors for approval and it was approved on the 20th of June 2022.

3.18. Publication of the SOC-8 and dissemination of the Standards of Care

The Standards of Care was disseminated in a number of venues and in a number of formats including publication in the International Journal of Transgender Health (the official scientific journal of WPATH).

4. Plan to Update

A new edition of the SOC (SOC-9) will be developed in the future, when new evidence and/or significant changes in the field necessitating a new edition is substantial.

*The development of SOC-8 was a complex process at a time of COVID-19 and political uncertainties in many parts of the world. Members of the SOC-8 worked on the SOC-8 on top of their day-to-day job, and most of the meetings took place out of their working time and during their weekends via Zoom. There were very few face-to-face meetings, most of them linked to WPATH, USPATH or EPATH conferences. Committee members of the SOC-8 were not paid as part of this process.

Appendix B GLOSSARY

CISGENDER refers to people whose current gender identity corresponds to the sex they were assigned at birth.

DETRANSITION is a term sometimes used to describe an individual's retransition to the gender stereotypically associated with their sex assigned at birth.

EUNUCH refers to an individual assigned male at birth whose testicles have been surgically removed or rendered non-functional and who identifies as a eunuch. This differs from the standard medical definition by excluding those who do not identify as eunuch.

EUNUCH-IDENTIFIED: An individual who feels their true self is best expressed by the term eunuch. Eunuch-identified individuals generally desire to have their reproductive organs surgically removed or rendered non-functional.

GENDER: Depending on the context, gender may reference gender identity, gender expression, and/or social gender role, including understandings and expectations culturally tied to people who were assigned male or female at birth. Gender identities other than those of men and women (who can be either cisgender or transgender) include transgender, nonbinary, genderqueer, gender neutral, agender, gender fluid, and "third" gender, among others; many other genders are recognized around the world.

GENDER-AFFIRMATION refers to being recognized or affirmed in a person's gender identity. It is usually conceptualized as having social, psychological, medical, and legal dimensions. Gender affirmation is used as a term in lieu of transition (as in medical gender-affirmation) or can be used as an adjective (as in gender-affirming care).

GENDER-AFFIRMATION SURGERY (GAS) is used to describe surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity.

GENDER BINARY refers to the idea there are two and only two genders, men and women; the expectation that everyone must be one or the other; and that all men are males, and all women are females.

GENDER DIVERSE is a term used to describe people with gender identities and/or expressions that are different from social and cultural expectations attributed to their sex assigned at birth. This may include, among many other culturally diverse identities, people who identify as nonbinary, gender expansive, gender nonconforming, and others who do not identify as cisgender.

GENDER DYSPHORIA describes a state of distress or discomfort that may be experienced because a person's gender identity differs from that which is physically and/or socially attributed to their sex assigned at birth. Gender Dysphoria is also a diagnostic term in the DSM-5 denoting an incongruence between the sex assigned at birth and experienced gender accompanied by distress. Not all transgender and gender diverse people experience gender dysphoria.

GENDER EXPANSIVE is an adjective often used to describe people who identify or express themselves in ways that broaden the socially and culturally defined behaviors or beliefs associated with a particular sex. Gender creative is also sometimes used. The term gender variant was used in the past and is disappearing from professional usage because of negative connotations now associated with it.

GENDER EXPRESSION refers to how a person enacts or expresses their gender in everyday life and within the context of their culture and society. Expression of gender through physical appearance may include dress, hairstyle, accessories, cosmetics, hormonal and surgical interventions as well as mannerisms, speech, behavioral patterns, and names. A person's gender expression may or may not conform to a person's gender identity.

GENDER IDENTITY refers to a person's deeply felt, internal, intrinsic sense of their own gender.

GENDER INCONGRUENCE is a diagnostic term used in the ICD-11 that describes a person's marked and persistent experience of an incompatibility between that person's gender identity and the gender expected of them based on their birth-assigned sex.

INTERSEX refers to people born with sex or reproductive characteristics that do not fit binary definitions of female or male.

MISGENDER/MISGENDERING refers to when language is used that does not correctly reflect the gender with which a person identifies. This may be a pronoun (he/him/his, she/her/hers, they/them/theirs) or a form of address (sir, Mr.).

NONBINARY refers to those with gender identities outside the gender binary. People with nonbinary gender identities may identify as partially a man and partially a woman or identify as sometimes a man and sometimes a woman, or identify as a gender other than a man or a woman, or as not having a gender at all. Nonbinary people may use the pronouns they/them/theirs instead of he/him/his or she/her/hers. Some nonbinary people consider themselves to be transgender or trans; some do not because they consider transgender to be part of the gender binary. The shorthand NB or "enby" is sometimes used as a descriptor for nonbinary. Examples of nonbinary gender identities are genderqueer, gender diverse, genderfluid, demigender, bigender, and agender.

RETRANSITION refers to second or subsequent gender transition whether by social, medical, or legal means. A retransition may be from one binary or nonbinary gender to another binary or nonbinary gender. People may retransition more than once. Retransition may occur for many reasons, including evolving gender identities, health concerns, family/societal concerns, and financial issues.

SEX ASSIGNED AT BIRTH refers to a person's status as male, female, or intersex based on physical characteristics. Sex is usually assigned at birth based on appearance of the external genitalia. AFAB is an abbreviation for "assigned female at birth." AMAB is an abbreviation for "assigned male at birth."

SEXUAL ORIENTATION refers to a person's sexual identity, attractions, and behaviors in relation to people on the basis of their gender(s) and or sex characteristics and those of their partners. Sexual orientation and gender identity are distinct terms.

TRANSGENDER or trans are umbrella terms used to describe people whose gender identities and/or gender expressions are not what is typically expected for the sex to which they were assigned at birth. These words should always be used as adjectives (as in "trans people") and never as nouns (as in "transgenders") and never as verbs (as in "transgendered").

TRANSGENDER MEN or **TRANS MEN** or **MEN OF TRANS EXPERIENCE** are people who have gender identities as men and who were assigned female at birth. They may or may not have undergone any transition. FTM or Female-to-Male are older terms that are falling out of use.
TRANSGENDER WOMEN or **TRANS WOMEN** or **WOMEN OF TRANS EXPERIENCE** are people who have gender identities as women and who were assigned male at birth. They may or may not have undergone any transition. MTF or Male-to-Female are older terms that are falling out of use.
TRANSITION refers to the process whereby people usually change from the gender expression associated with their assigned sex at birth to another gender expression that better matches their gender identity. People may transition socially by using methods such as changing their name, pronoun, clothing, hair styles, and/or the ways that they move and speak. Transitioning may or may not involve hormones and/or surgeries to alter the physical body. Transition can be used to describe the process of changing one's gender expression from any gender to a different gender. People may transition more than once in their lifetimes.
TRANSPHOBIA refers to negative attitudes, beliefs, and actions concerning transgender and gender diverse people as a group. Transphobia may be enacted in discriminatory policies and practices on a structural level or in very specific and personal ways. Transphobia can also be internalized, when transgender and gender diverse people accept and reflect such prejudice about themselves or other transgender and gender diverse people. While transphobia sometimes may be a result of unintentional ignorance rather than direct hostility, its effects are never benign. Some people use the term anti-transgender bias in place of transphobia.

Appendix C GENDER-AFFIRMING HORMONAL TREATMENTS

Table 1. Expected time course of physical changes in response to gender-affirming hormone therapy

Testosterone Based Regimen		
Effect	**Onset**	**Maximum**
Skin Oiliness/acne	1–6 months	1–2 years
Facial/body hair growth	6–12 months	>5 years
Scalp hair loss	6–12 months	>5 years
Increased muscle mass/ strength	6–12 months	2–5 years
Fat redistribution	1–6 months	2–5 years
Cessation of menses	1–6 months	1–2 years
Clitoral enlargement	1–6 months	1–2 years
Vaginal atrophy	1–6 months	1–2 years
Deepening of voice	1–6 months	1–2 years
Estrogen and testosterone-lowering based regimens		
Effect	**Onset**	**Maximum**
Redistribution of body fat	3–6 months	2–5 years
Decrease in muscle mass and strength	3–6 months	1–2 years
Softening of skin/ decreased oiliness	3–6 months	Unknown
Decreased sexual desire	1–3 months	Unknown
Decreased spontaneous erections	1–3 months	3–6 months
Decreased sperm production	Unknown	2 years
Breast growth	3–6 months	2–5 years
Decreased testicular volume	3–6 months	Variable
Decreased terminal hair growth	6–12 months	> 3 years
Increased scalp hair	Variable	Variable
Voice changes	None	

Adapted from Hembree et al., 2017.

Table 2. Risks associated with gender affirming hormone therapy (bolded items are clinically significant) (Updated from SOC-7)

RISK LEVEL	Estrogen-based regimens	Testosterone-based regimens
Likely increased risk	**Venous Thromboembolism** **Infertility** Hyperkalemia[S] Hypertrigyceridemia Weight Gain	**Polycythemia** **Infertility** Acne Androgenic Alopecia Hypertension Sleep Apnea Weight Gain Decreased HDL Cholesterol and increased LDL Cholesterol
Likely increased risk with presence of additional risk factors	Cardiovascular Disease Cerebrovascular Disease Meningioma[C] Polyuria/Dehydration[S] Cholelithiasis	Cardiovascular Disease Hypertriglyceridemia
Possible increased risk	Hypertension Erectile Dysfunction	
Possible increased risk with presence of additional risk factors	Type 2 Diabetes Low Bone Mass/ Osteoporosis Hyperprolactinemia	Type 2 Diabetes Cardiovascular Disease
No increased risk or inconclusive	Breast and Prostate Cancer	Low Bone Mass/ Osteoporosis Breast, Cervical, Ovarian, Uterine Cancer

[C]cyproterone-based regimen
[S]spironolactone-based regimen

Table 3. Gender-Affirming Hormone Regimens In Transgender And Gender Diverse Youth (Adapted from the Endocrine Society Guidelines; Hembree et al., 2017)

Induction of female puberty (estrogen-based regimen) with oral 17ß-estradiol
Initiate at 5µg/kg/d and increase every 6 months by 5 µg/kg/d up to 20 µg/kg/d according to estradiol levels
Adult dose = 2-6 mg/day
In postpubertal TGD adolescents, the dose of 17ß-estradiol can be increased more rapidly:
1 mg/d for 6 months followed by 2 mg/d and up according to estradiol levels
Induction of female puberty (estrogen-based regimen) with transdermal 17ß-estradiol
Initial dose 6.25-12.5 µg/24 h (cutting 24 g patch to ¼ then ½)
Titrate up by every 6 months by 12.5 µg/24 h according to estradiol levels
Adult dose = 50-200 µg/24 hours
For alternatives once at adult dose (Table 4)
Induction of male puberty (testosterone-based regimen) with testosterone esters
25 mg/m^2/2 weeks (or alternatively half this dose weekly)
Increase by 25 mg/m^2/2 weeks every 6 months until adult dose and target testosterone levels are achieved. See alternatives for testosterones (Table 4)

Table 4. Hormone regimens in transgender and gender diverse adults*

Estrogen-based regimen (Transfeminine)	
Estrogen	
Oral or sublingual	
Estradiol	2.0-6.0 mg/day
Transdermal	
Estradiol transdermal patch	0.025-0.2 mg/day
Estradiol gel various	‡ daily to skin
Parenteral	
Estradiol valerate or cypionate	5-30 mg IM every 2 weeks 2-10 IM every week
Anti-Androgens	
Spironolactone	100–300 mg/day
Cyproterone acetate	10 mg/day**
GnRH agonist	3.75–7.50 mg SQ/IM monthly
GnRH agonist depot formulation	11.25/22.5 mg SQ/IM 3/6 monthly
‡ Amount applied varies to formulation and strength	
Testosterone-Based Regimen (Transmasculine)	
Transgender males	
Testosterone	
Parenteral	
Testosterone enanthate/ cypionate	50–100 IM/SQ weekly or 100–200 IM every 2 weeks
Testosterone undecanoate	1000 mg IM every 12 weeks or 750 mg IM every 10 weeks
Transdermal testosterone	
Testosterone gel	50-100 mg/day
Testosterone transdermal patch	2.5–7.5 mg/day

Doses are titrated up or down until sex steroid hormone levels are in the therapeutic range. Hormone regimens do not reflect all formulations that are available in all pharmacies throughout the world. Hormone regimens may have to be adapted to what is available in local pharmacies.
**Kuijpers et al (2021).

Table 5. Hormone monitoring of transgender and gender diverse people receiving gender-affirming hormone therapy (Adapted from the Endocrine Society Guidelines)

Transgender male or trans masculine (including gender diverse/nonbinary) individuals

1. Evaluate patient approximately every 3 months (with dose changes) in the first year and 1 to 2 times per year thereafter to monitor for appropriate physical changes in response to testosterone.
2. Measure serum total testosterone every 3 months (with dose changes) until levels are at goal
   a. For parenteral testosterone, the serum total testosterone should be measured midway between injections. The target level is 400-700 ng/dL. Alternatively, measure peak and trough peaks to ensure levels remain in the range of reference men.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before injection. If the level is < 400 ng/dL, adjust the dosing interval.
   c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 week of daily application (at least 2 hours after application of product).
3. Measure hematocrit or hemoglobin concentrations at baseline and approximately 3 months (with dose changes) for the first year and then one to two times a year.

Transgender Female or trans feminine (including gender diverse/nonbinary) individuals

1. Evaluate patient approximately every 3 months (with dose changes) in the first year and one to two times per year thereafter to monitor for appropriate physical changes in response to estrogen.
   a. Serum testosterone levels should be less than 50 ng/dL.
   b. Serum estradiol should be in the range of 100-200 pg/mL.
2. For individuals receiving spironolactone, serum electrolytes, in particular potassium, and kidney function, in particular creatinine, should be monitored.
3. Follow primary care screening per primary care chapter recommendations

Appendix D SUMMARY CRITERIA FOR HORMONAL AND SURGICAL TREATMENTS FOR ADULTS AND ADOLESCENTS

The SOC-8 guidelines are intended to be flexible in order to meet the diverse health care needs of TGD people globally. While adaptable, they offer consensus-based standards derived from the best available scientific evidence for promoting optimal health care and guiding the treatment of people experiencing gender incongruence. As in all previous versions of the SOC, the criteria put forth in this document for gender affirming interventions are clinical guidelines; individual health care professionals and programs, in consultation with the TGD person, may modify them. Clinical departures from the SOC may occur due to a TGD person's unique anatomic, social, or psychological situation; an experienced health care professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, discussed with the TGD person, and documented. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care—and the SOC—to evolve. This summary criteria needs to be read in conjunction with the relevant chapters (see Adult Assessment and Adolescent chapters).

SUMMARY CRITERIA FOR ADULTS

Related to the assessment process

- Health care professionals assessing transgender and gender diverse adults seeking gender-affirming treatment should liaise with professionals from different disciplines within the field of trans health for consultation and referral, if required*
- If written documentation or a letter is required to recommend gender affirming medical and surgical treatment (GAMST), only one letter of assessment from a health care professional who has competencies in the assessment of transgender and gender diverse people is needed.

Criteria for hormones

a. Gender incongruence is marked and sustained;
b. Meets diagnostic criteria for gender incongruence prior to gender-affirming hormone treatment in regions where a diagnosis is necessary to access health care;
c. Demonstrates capacity to consent for the specific gender-affirming hormone treatment;
d. Other possible causes of apparent gender incongruence have been identified and excluded;
e. Mental health and physical conditions that could negatively impact the outcome of treatment have been assessed, with risks and benefits discussed;
f. Understands the effect of gender-affirming hormone treatment on reproduction and they have explored reproductive options.

Criteria for surgery

a. Gender incongruence is marked and sustained;
b. Meets diagnostic criteria for gender incongruence prior to gender-affirming surgical intervention in regions where a diagnosis is necessary to access health care;
c. Demonstrates capacity to consent for the specific gender-affirming surgical intervention;
d. Understands the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options;
e. Other possible causes of apparent gender incongruence have been identified and excluded;
f. Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits have been discussed;
g. Stable on their gender affirming hormonal treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).*

*These were graded as suggested criteria

SUMMARY CRITERIA FOR ADOLESCENTS

Related to the assessment process

- A comprehensive biopsychosocial assessment including relevant mental health and medical professionals;
- Involvement of parent(s)/guardian(s) in the assessment process, unless their involvement is determined to be harmful to the adolescent or not feasible;
- If written documentation or a letter is required to recommend gender-affirming medical and surgical treatment (GAMST), only one letter of assessment from a member of the multidisciplinary team is needed. This letter needs to reflect the assessment and opinion from the team that involves both medical and mental health professionals (MHPs).

Puberty blocking agents

a. Gender diversity/incongruence is marked and sustained over time;
b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
c. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
d. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
e. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
f. Reached Tanner stage 2.

Hormonal treatments

a. Gender diversity/incongruence is marked and sustained over time;
b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
c. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
d. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
e. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
f. Reached Tanner stage 2.

Surgery

a. Gender diversity/incongruence is marked and sustained over time;
b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
c. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
d. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
e. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
f. At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

Appendix E GENDER-AFFIRMING SURGICAL PROCEDURES

As the field's understanding of the many facets of gender incongruence expands, and as technology develops which allows for additional treatments, it is imperative to understand this list is not intended to be exhaustive. This is particularly important given the often lengthy time periods between updates to the SOC, during which evolutions in understanding and treatment modalities may occur.

FACIAL SURGERY	
Brow	• Brow reduction • Brow augmentation • Brow lift
Hair line advancement and/or hair transplant	
Facelift/mid-face lift (following alteration of the underlying skeletal structures)	
Facelift/mid-face lift (following alteration of the underlying skeletal structures)	• Platysmaplasty
Blepharoplasty	• Lipofilling
Rhinoplasty (+/- fillers)	
Cheek	• Implant • Lipofilling
Lip	• Upper lip shortening • Lip augmentation (includes autologous and non-autologous)
Lower jaw	• Reduction of mandibular angle • Augmentation
Chin reshaping	• Osteoplastic • Alloplastic (implant-based)
Chondrolaryngoplasty	• Vocal cord surgery (see voice chapter)
BREAST/CHEST SURGERY	
Mastectomy	• Mastectomy with nipple-areola preservation/reconstruction as determined medically necessary for the specific patient • Mastectomy without nipple-areola preservation/reconstruction as determined medically necessary for the specific patient
Liposuction	
Breast reconstruction (augmentation)	• Implant and/or tissue expander • Autologous (includes flap-based and lipofilling)
GENITAL SURGERY	
Phalloplasty (with/without scrotoplasty)	• With/without urethral lengthening • With/without prosthesis (penile and/or testicular) • With/without colpectomy/colpocleisis
Metoidioplasty (with/without scrotoplasty)	• With/without urethral lengthening • With/without prosthesis (penile and/or testicular) • With/without colpectomy/colpocleisis
Vaginoplasty (inversion, peritoneal, intestinal)	• May include retention of penis and/or testicle
Vulvoplasty	• May include procedures described as "flat front"
GONADECTOMY	
Orchiectomy	
Hysterectomy and/or salpingo-oophorectomy	
BODY CONTOURING	
Liposuction	
Lipofilling	
Implants	• Pectoral, hip, gluteal, calf
Monsplasty/mons reduction	
ADDITIONAL PROCEDURES	
Hair removal: Hair removal from the face, body, and genital areas for gender affirmation or as part of a preoperative preparation process. (see Statement 15.14 regarding hair removal)	• Electrolysis • Laser epilation
Tattoo (i.e., nipple-areola)	
Uterine transplantation	
Penile transplantation	

Exclusionary bathroom policies harm transgender students

APR 17, 2019

Tanya Albert Henry
Contributing News Writer

For the sake of transgender students' physical and mental health, the AMA and other medical societies are urging a federal appeals court to uphold an Oregon school district's policy allowing transgender students to use bathrooms and locker rooms that match their gender identities.

Denying transgender students this access endangers their health, safety and well-being, leads to negative health outcomes and heightens stigma and discrimination, says the amicus brief filed by the AMA, the Oregon Medical Association and a dozen other mental health and health care organizations. They filed the brief in the 9th U.S. Circuit Court of Appeals.

A group of parents of cisgender students filed a lawsuit challenging the Oregon school district's policy, saying it violated their children's right to privacy. Last summer, a federal district court judge in Oregon ruled the policy didn't violate cisgender students' privacy. Now those parents are appealing the decision in the case, Parents for Privacy v. Dallas School District No. 2.

AMA policy supports transgender individuals' use of public restrooms in line with their gender identities, and the amicus brief informs the federal court about gender dysphoria and transgender health research.

For example, living one's life in accordance with one's gender identity is often critical to mental health. That can include adopting a new name, dressing in a way associated with one's gender identity, and using restrooms and other single-sex facilities consistent with the identity, the brief says.

"Exclusionary policies require transgender individuals to live one facet of their lives in contradiction with their gender identity," the brief explains. Such "policies threaten to exacerbate the risk of anxiety and depression, low self-esteem, engaging in self-injurious behaviors, suicide, substance use, homelessness and eating disorders, among other adverse outcomes."

And these are risks that are already higher among transgender people. The brief points to the Report of the 2015 U.S. Transgender Survey from the National Center for Transgender Equality, which surveyed 27,000 transgender people and found that 40% reported a suicide attempt. That rate is nine times higher than in the general U.S. population.

Exposed to harassment and abuse

Transgender students may have transitioned before arriving at a school and forcing them to use facilities that do not match how they live and are recognized in the world may forcibly out them to their peers as transgender. That is harmful, the AMA brief tells the court.

"These policies rob transgender individuals of the personal choice of whether and when to reveal their status. It is often anxiety-inducing and fraught," the brief states.

The compelled disclosure also opens up students to potential harassment and abuse. Nearly 70% of transgender survey respondents reported verbal harassment and 9% reported at physical assault in gender-segregated bathrooms, the brief says, citing research from 2013.

UTIs, constipation can result

Exclusionary policies also force transgender students to decide whether to violate the policy and potentially face disciplinary actions; use a bathroom that doesn't match their gender identity or use a special bathroom that no other students are required to use; or not use any restroom.

None are good choices, the AMA brief tells the court, saying that "this difficult choice produces heightened anxiety and distress around restroom use, which may make it difficult for transgender individuals to concentrate or focus at school or work and potentially cause them to eschew social activities or everyday tasks."

And students who avoid using the restroom can have medical consequences, the brief states, including recurrent urinary tract infections and constipation, as well as the possibility of more serious health complications, including hematuria and chronic kidney disease.

Welcoming school, better outcomes

On the flip side, numerous studies show that more welcoming, safer school environments result in lower rates of depression, suicidality and other negative health outcomes, the AMA tells the court, concluding that the court should uphold the lower court ruling that kept the Oregon school policy in place.

California DEPARTMENT OF EDUCATION

Legal Advisory

Legal Advisory regarding application of California's antidiscrimination statutes to transgender youth in schools.

This advisory replaces LO: 1-04, dated April 30, 2004, regarding application of California's antidiscrimination statutes to transgender youth in schools. The purpose of this advisory is to provide California school districts with updated guidance on the minimum requirements for compliance with California's prohibition on gender identity discrimination.

State and federal law generally prohibits discrimination, harassment, intimidation and bullying of students based on their actual or perceived sex, gender, sexual orientation, gender identity or expression, race, color, ancestry, national origin, ethnic group identification, age, religion, marital or parental status, physical or mental disability or genetic information, or association with a person or group with one or more of these actual or perceived characteristics. (Education Code sections 220, 234.1; 42 U.S.C. sections 2000d-2000e-17, 2000h-2000h-6.)

In addition, Education Code Section 234.1, as amended by AB 9 (Ch. 728, Statutes of 2011), and Section 235, mandate that school districts("districts"), including charter or alternative schools, adopt a policy prohibiting discrimination, harassment, intimidation and bullying based on the above categories at school or in any school activity related to school attendance or under the authority of the district. Education Code Section 234.1 further requires districts to adopt a process requiring school personnel to immediately intervene, when it is safe to do so, whenever they witness acts of discrimination, harassment, intimidation or bullying based on the characteristics specified in Education Code sections 220 or 234.1 or Penal Code Section 422.55, including gender identity.

Education Code Section 221.5 specifically prohibits discrimination on the basis of sex with regard to enrollment in classes or courses, career counseling and availability of physical education activities or sports to both sexes.

In 2013, AB 1266 amended Education Code Section 221.5 to clarify that students must be permitted to participate in sex-segregated school programs and activities, including athletic teams and competitions, and use facilities consistent with their gender identity, regardless of the gender listed in their student records. Even prior to the passage of AB 1266, the U.S. Department of Education's Office for Civil Rights and U.S. Department of Justice's Civil Rights Division investigated a civil rights complaint based on *federal* law against Arcadia Unified School District by a transgender student. The district agreed to provide transgender and gender-nonconforming students with equal access to district facilities, programs and activities consistent with their gender identity. (*See* Resolution Agreement (PDF))

Therefore, California and federal law require schools to afford students equal opportunity and access to the school's facilities, activities, and programs, in a manner that is consistent with each student's gender identity, irrespective of whether the student's gender identity matches the student's assigned sex at birth. Education Code Section 210.7 (defining "gender" to include "a person's gender-related appearance and behavior whether or not stereotypically associated with the person's assigned sex at birth."). Creating that type of school environment will help ensure that all students will be provided an environment that will nurture their growth, both academically and developmentally.

The Department has prepared FAQs which address key issues regarding the requirements and implementation of AB 1266. These issues are: (1) privacy with respect to the student's transgender status; (2) names and pronouns; (3) school records; (4) dress codes and uniforms; (5) restrooms and locker rooms; (6) physical education classes and school sports; and (7) protection from harassment. The FAQs also contain a glossary of definitions and list of helpful resources, including a model board policy and administrative regulation developed by the California School Boards Association for adoption by districts. It is recommended that these materials are reviewed by superintendents, principals, administrators and the local educational agency officer appointed pursuant to Education Code Section 234.1(g) to ensure compliance with the educational equity and nondiscrimination requirements of Education Code Section 200 et seq. and 5 California Code of Regulations Section 4900 et seq.

California law requires that schools provide all students with a safe, supportive and inclusive learning environment, free from discrimination, harassment, and bullying. Examples of harassment and abuse commonly experienced by transgender students include, but are not limited to, being teased for failing to conform to sex stereotypes, being deliberately referred to by the name and/or pronouns associated with the student's assigned sex at birth, being deliberately excluded from peer activities, and having personal items stolen or damaged. School district efforts to prevent and address harassment must include strong local policies and procedures for handling complaints of harassment, consistent and effective implementation of those policies, and encouraging members of the school community to report incidents of harassment. Beyond investigating incidents, schools should implement appropriate corrective action to end the harassment and monitor the effectiveness of those actions.

If you have further questions regarding this legal advisory, please contact us.

Questions: School Health and Safety Office | shso@cde.ca.gov | 916-319-0914

Last Reviewed: Thursday, February 29, 2024

Administrative Regulation 5161

GENDER IDENTITY AND GENDER NON-CONFORMITY - STUDENTS

Responsible Office: Office of School Leadership

PURPOSE

This administrative regulation establishes protocols and informs staff regarding transgender and gender non-conforming students in the Washoe County School District ("District" or "WCSD").

REGULATION

1. The District is committed to addressing the health and safety needs of all students, including those needs related to a student's actual or perceived gender identity. A safe and respectful environment is necessary for students to have equal access to all school programs and activities and is integral to student success. The District acknowledges its role in providing student with an understanding, appreciation of, and respect for the differences of others.
2. This administrative regulation does not anticipate every situation that might occur and, therefore, the needs of each student must be assessed on a case-by-case basis. In all cases, the goal is to foster the safe and healthy development of the transgender or gender non-conforming student while maximizing the student's social integration into the school setting and minimizing stigmatization of the student.
3. The District will not require proof of medical treatments as a prerequisite for respecting a student's gender identity or expression.
4. If a student has demonstrated a consistent, insistent, and persistent gender presentation over a period of time, school staff and volunteers shall not question whether that student's asserted gender identity is genuinely held.
5. Rights and Protections
    a. Right to Privacy –
        i. Transgender and gender non-conforming students have a right to privacy, including keeping private their sexual orientation, gender identity, transgender status, or gender non-conforming presentation at school. Transgender and gender non-conforming students have the right to discuss and express their gender identity and expression openly and to decide when, with whom, and how much to share their private information.
        ii. Staff shall not disclose information that may reveal a student's transgender or gender non-conforming status to others, including parents/guardians or other staff members, unless there is a specific

"need to know," they are legally required to do so, or the student has authorized such disclosure.

iii. Staff must be mindful of the confidentiality and privacy rights of students when contacting parents/guardians so as to not reveal, imply or refer to a student's actual or perceived sexual orientation, gender identity, or gender expression.

b. Names/Pronouns – Students have the right to be addressed by the names and pronouns that correspond to their gender identity. Using the student's declared name and pronoun promotes the safety and wellbeing of the student. When possible, the requested name shall be included in the District's electronic database in addition to the student's legal name, in order to inform faculty and staff, to include substitute teachers and classroom volunteers, of the name and pronoun to use when addressing the student.

i. A student is not required to change his/her official school record or obtain a court-ordered name or gender change in order to be addressed at school by the name and pronoun which corresponds to their gender identity. Such a request may be made by the student or by the student's parent/guardian.

ii. If a student obtains a court order changing his/her name or recognized gender, the student or student's parent/guardian should notify the school of the court order and the official school records will be modified as appropriate in accordance with the court order.

c. Restroom Access – Students shall have access to the restroom that corresponds to their gender identity as expressed by the student and asserted at school. Transgender and gender non-conforming students shall not be forced to use the restroom corresponding to their physiological or biological sex at birth, nor an alternative restroom such as in the health clinic.

i. If a transgender or gender non-conforming student or the student's parent/guardian provides notice to the school principal of a reason or desire for increased privacy and/or safety with regard to restroom use, regardless of the underlying reasons, the school shall take reasonable steps to provide a reasonable accommodation for the student, including but not limited to, providing the student access to gender neutral unisex restroom facilities or a single stall restroom. However, no student shall be compelled to use such bathroom.

d. Locker Rooms or Other Facilities – Students shall have access to use facilities that correspond to their gender identity as expressed by the student and asserted at school, irrespective of the gender listed on the

student's records, including but not limited to locker rooms. Transgender and gender non-conforming students shall not be forced to use the locker room corresponding to their physiological or biological sex at birth.

i. If a transgender or gender non-conforming student or the student's parent or /guardian provides notice to school officials a reason or desire for increased privacy and/or safety with regard to locker room use, regardless of the underlying reason, the student shall be provided access to a reasonable alternative locker room. The use of such accommodations shall be a matter of choice for a student and no student shall be compelled to use such accommodations. Such accommodations may include but not limited to:

1. Use of a private area in the public area (e.g., a nearby restroom stall with a door, an area separated by a curtain, a P.E. instructor's office in the locker room, or a nearby gender neutral restroom);
2. A separate changing schedule (either utilizing the locker room before or after the other students); or
3. Use of a nearby private area (e.g., a nearby restroom, a nurse's office).

e. Physical Education Class and Athletics – Transgender and gender non-conforming students shall be permitted to participate in physical education classes and intramural sports in a manner that is consistent with their gender identity.

f. Interscholastic Competitive Sports Teams – Participation in interscholastic athletics by transgender and gender non-conforming students in a manner consistent with their gender identity will be addressed on a case-by-case basis, consistent with the rules and bylaws governing interscholastic sports competition, the Nevada Interscholastic Activities Association (NIAA), Title IX, and any other applicable laws, rules or bylaws.

g. Dress Code – The District shall not implement a dress code that is gender-based. Transgender and/or gender non-conforming students have the right to dress in accordance with the gender identity or gender expression that they consistently assert at school and within the requirements of the school's dress code or site-based school uniform policy.

h. Yearbook Photos – Schools shall offer one of two alternatives in order to accommodate the needs of transgender and gender non-conforming students: (1) Allow students the option to select their preferred picture attire or "uniform", regardless of their biological sex and which is consistent with the student's asserted gender identity; or (2) Adopt a standardized, gender neutral picture "uniform" such as a cap and gown.

i. Academic Programming – the District discourages, within academic programming, the separation of students based upon gender unless it serves a compelling instructional or academic interest.

j. Gender Segregation in Other Activities – In other circumstances where students are separated by gender in school activities (e.g. class discussions, field trips, etc.), transgender and gender non-conforming students shall be permitted to participate in accordance with their gender identity that is asserted at school. Activities that may involve the need for accommodation to address student privacy concerns will be addressed on a case-by-case basis. In such circumstances, staff shall make a reasonable effort to provide an available and reasonable accommodation for the student that can address any such concerns.

k. Official Records – the District is required to maintain a mandatory permanent record which includes the legal name of the student, as well as the student's gender. The District shall only change a student's official records to reflect a change in legal name or gender upon receipt of documentation that such legal name and/or gender have been changed in accordance with Nevada legal requirements.

6. Terminology

a. The following are examples of ways in which transgender and gender nonconforming youth describe their lives and gendered experiences: trans, transsexual, transgender, male-to-female (MTF), female-to-male (FTM), bi-gender, two-spirit, trans man, and trans woman.

b. Faculty and staff may inquire which terms students may prefer and avoid terms that make these students uncomfortable; a good general guideline is to employ those terms which the students use to describe themselves.

7. Discrimination, Harassment and Bullying Complaints

a. Concerns and/or complaints should be brought to the attention of the school principal immediately. The District provides several reporting mechanisms to include:

i. Online at: www.wcsdbullying.com

ii. By phone via Secret Witness at: 775-329-6666

iii. Written or verbal to the school principal or other staff member

b. A formal complaint of discrimination, harassment, intimidation or bullying based upon a student's transgender or gender non-conforming status, or a student's sex, gender, sexual orientation or gender identity may be brought under Board Policy 9200, Harassment and Discrimination Prohibited, Board Policy 5700, Safe and Respectful Learning Environment, the associated administrative regulations and the procedures set forth

therein. Incidents and/or allegations shall be given immediate attention which include, but are not limited to, the following:

i. Intervening immediately to stop the discrimination, harassment, bullying and/or violent behavior;

ii. Investigating the incident;

iii. Determining and enforcing corrective actions, as appropriate;

iv. Monitoring to ensure the behavior does not persist.

c. The intentional or persistent refusal to respect a student's gender identity, such as by referring to the student by a name or pronoun that does not correspond to the student's gender identity, may be considered a violation of Board Policy 9200, Harassment and Discrimination Prohibited, as well as this administrative regulation.

DEFINITIONS

1. These definitions are provided not for the purpose of labeling students but to assist in understanding this document and the legal obligations of faculty and staff.

   a. Gender Expression - The manner in which a person represents or expresses gender to others, often through behavior, clothing, hairstyles, activities, voice or mannerisms.

   b. Gender Identity: An individual's understanding, outlook, feelings and sense of being masculine, feminine, both or neither, regardless of one's biological sex.

   c. Gender Nonconforming - A term for people whose gender expression differs from stereotypical expectations, such as "feminine" boys, "masculine" girls, and those who are perceived as androgynous. This includes people who identify outside traditional gender categories or identify as both genders. Other terms that can have similar meanings include gender diverse or gender expansive.

   d. Gender Non-conforming / Variant: an individual who is, or is perceived to have, characteristics or behaviors that do not conform to societal expectations of gender expression. Gender non-conforming or variant individuals may or may not identify as lesbian, gay, bisexual, transgender or questioning.

   e. Sexual Orientation means having or being perceived as having an orientation, such as heterosexuality, homosexuality or bisexuality. Individuals may identify their sexual orientation as heterosexual, lesbian, gay, bisexual, questioning, or in other terms. Not all transgender youth identify as gay, lesbian, bisexual or questioning, and not all gay, lesbian,

bisexual and questioning youth display gender non-conforming characteristics.

f. Transgender – A term used to describe a person whose gender identity or expression is different from that traditionally associated with an assigned sex at birth. Other terms that can have similar meanings are transsexual and trans.

g. Transition - The process in which a person goes from living and identifying as one gender to living and identifying as another.

DESIRED OUTCOMES

1. The District, through this administrative regulation, seeks to foster an educational environment that is safe and free from discrimination for all students, faculty and staff, parents/guardians, volunteers and visitors, regardless of gender identity or gender expression.
2. This administrative regulation:
    a. Seeks to facilitate compliance with local, state, and federal laws concerning bullying, harassment and discrimination and to ensure that school and district policies do not discriminate against transgender and gender non-conforming students.
    d. Documents the District's intent to reduce the stigmatization of and improve the educational integration of transgender and gender non-conforming students, maintain the privacy of all students, and foster cultural competence and professional development for faculty and staff.
    e. Will support healthy communication between the District and parents/guardians to further the successful educational development and well-being of every student.

IMPLEMENTATION GUIDELINES & ASSOCIATED DOCUMENTS

1. This administrative regulation reflects the goals of the District's Strategic Plan and aligns/complies with the governing documents of the District, to include:
    a. Board Policy 9200, Harassment and Discrimination Prohibited
    b. Board Policy 5700, Safe and Respectful Learning Environment
2. This administrative regulation complies with Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC), to include:
    a. Chapter 386, Local Administrative Organization
        i. NRS 386.420 – 386.470, Nevada Interscholastic Activities Association
    b. Chapter 388, System of Public Instruction

i. NRS 388.121 – 388.145, Provision of Safe and Respectful Learning Environment

c. Chapter 392, Pupils

3. This administrative regulation complies with federal laws and regulations to include:

a. Title VI of the Civil Rights Act of 1964

b. Title IX of the Education Amendments of 1972

REVIEW AND REPORTING

1. This document shall be reviewed as part of the bi-annual review and reporting process, following each regular session of the Nevada Legislature. The Board of Trustees shall receive notification of any required changes to the associated policy.
2. Administrative regulations, and/or other associated documents, will be developed as necessary to implement this document. The Board of Trustees and Superintendent shall receive notification of the adoption and/or revision of any associated administrative regulations.

REVISION HISTORY

Date	Revision	Modification
2/12/2015	1.0	Adopted
4/3/2019	2.0	Revised to add language referring to "insistent, persistent, and consistent" demonstration of gender

International Olympic Committee

IOC FRAMEWORK ON FAIRNESS, INCLUSION AND NON-DISCRIMINATION ON THE BASIS OF GENDER IDENTITY AND SEX VARIATIONS

INTRODUCTION

Every person has the right to practise sport without discrimination and in a way that respects their health, safety, and dignity. At the same time, the credibility of competitive sport – and particularly high-level organised sporting competitions – relies on a level playing field, where no athlete has an unfair and disproportionate advantage over the rest.

Through this Framework on Fairness, Inclusion and Non-Discrimination on the Basis of Gender Identity and Sex Variations, the International Olympic Committee (IOC) seeks to promote a safe and welcoming environment for everyone, consistent with the principles enshrined in the Olympic Charter. The Framework also acknowledges the central role that eligibility criteria play in ensuring fairness, particularly in high-level organised sport in the women's category.

This Framework is issued as part of the IOC's commitment to respecting human rights (as expressed in Olympic Agenda 2020+5) and as part of the action taken to foster gender equality and inclusion.

In issuing this Framework, the IOC recognises that it must be in the remit of each sport and its governing body to determine how an athlete may be at a disproportionate advantage against their peers, taking into consideration the nature of each sport. The IOC is therefore not in a position to issue regulations that define eligibility criteria for every sport, discipline or event across the very different national jurisdictions and sport systems.

Therefore, the aim of this Framework is to offer sporting bodies – particularly those in charge of organising elite-level competition – a principled approach to develop their criteria that are applicable to their sport. Sports bodies will also need to consider particular ethical, social, cultural and legal aspects that may be relevant in their context.

This Framework was developed following an extensive consultation with athletes and stakeholders concerned. This included members of the athlete community, International Federations and other sports organisations, as well as human rights, legal and medical experts. It replaces and updates previous IOC statements on this matter, including the 2015 Consensus Statement.

This Framework recognises both the need to ensure that everyone, irrespective of their gender identity or sex variations, can practise sport in a safe, harassment-free environment that recognises and respects their needs and identities, and the interest of everyone – particularly athletes at elite level – to participate in fair competitions where no participant has an unfair and disproportionate advantage over the rest.

International Olympic Committee

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International Olympic Committee

Lastly, the IOC also recognises that most high-level organised sports competitions are staged with men's and women's categories competing separately. In this context, the principles contained herein aim to ensure that competition in each of these categories is fair and safe and that athletes are not excluded solely on the basis of their transgender identity or sex variations.

Where eligibility criteria must be set in order to regulate the participation in the women's and men's categories, the establishment and implementation of such criteria should be carried out as part of a comprehensive approach grounded on the respect for internationally recognised human rights, robust evidence and athlete consultation. In so doing, precaution should be used to avoid causing harm to the health and well-being of athletes.

PRINCIPLES

This Framework should be considered as a coherent whole and should be taken into consideration by International Federations and other sports organisations when exercising their responsibility in establishing and implementing eligibility rules for high-level organised competition in their respective sports, disciplines and events and, more generally, in ensuring safe and fair competition in the context of inclusion and non-discrimination on the basis of gender identity and sex variations.

While these principles have been drafted with the specific needs of high-level organised sports competitions in mind, the general principles of inclusion and non-discrimination reflected below should be promoted and defended at all levels of sport.

1. INCLUSION

1.1. Everyone, regardless of their gender identity, expression and/or sex variations should be able to participate in sport safely and without prejudice.

1.2. Measures should be put in place with a view to making sporting environments and facilities welcoming to people of all gender identities.

1.3. Sports organisations should work together to advance inclusion and prevent discrimination based on gender identity and/or sex variations, through training, capacity-building and campaigns that are informed by affected stakeholders.

1.4. Mechanisms to prevent harassment and abuse in sport should be further developed by taking into account the particular needs and vulnerabilities of transgender people and people with sex variations.

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1.5. Where sports organisations choose to establish eligibility criteria in order to determine the participation conditions for men's and women's categories for specific contests in high-level organised sports competitions, these criteria should be established and applied in a manner that respects the principles included in this Framework. Individuals or parties responsible for issuing such criteria should be appropriately trained in order to ensure that these issues are handled in a manner consistent with these principles.

1.6. The design, implementation and evaluation of these measures and mechanisms should be done in consultation with a cross-section of affected athletes.

2. PREVENTION OF HARM

2.1 The physical, psychological and mental well-being of athletes should be prioritised when establishing eligibility criteria.

2.2. Sports organisations should identify and prevent negative direct and indirect impacts on athletes' health and well-being that may come from the design, implementation and or interpretation of eligibility criteria.

3. NON-DISCRIMINATION

3.1 Eligibility criteria should be established and implemented fairly and in a manner that does not systematically exclude athletes from competition based upon their gender identity, physical appearance and/or sex variations.

3.2 Provided they meet eligibility criteria that are consistent with principle 4, athletes should be allowed to compete in the category that best aligns with their self-determined gender identity.

3.3 Criteria to determine disproportionate competitive advantage may, at times, require testing of an athlete's performance and physical capacity. However, no athlete should be subject to targeted testing because of, or aimed at determining, their sex, gender identity and/or sex variations.

4. FAIRNESS

4.1 Where sports organisations elect to issue eligibility criteria for men's and women's categories for a given competition, they should do so with a view to:

a) Providing confidence that no athlete within a category has an unfair and disproportionate competitive advantage (namely an advantage gained by altering one's

body or one that disproportionately exceeds other advantages that exist at elite-level competition);

b) preventing a risk to the physical safety of other athletes; and

c) preventing athletes from claiming a gender identity different from the one consistently and persistently used, with a view to entering a competition in a given category.

5. NO PRESUMPTION OF ADVANTAGE

5.1 No athlete should be precluded from competing or excluded from competition on the exclusive ground of an unverified, alleged or perceived unfair competitive advantage due to their sex variations, physical appearance and/or transgender status.

5.2 Until evidence (per principle 6) determines otherwise, athletes should not be deemed to have an unfair or disproportionate competitive advantage due to their sex variations, physical appearance and/or transgender status.

6. EVIDENCE-BASED APPROACH

6.1 Any restrictions arising from eligibility criteria should be based on robust and peer reviewed research that:

a) demonstrates a consistent, unfair, disproportionate competitive advantage in performance and/or an unpreventable risk to the physical safety of other athletes;

b) is largely based on data collected from a demographic group that is consistent in gender and athletic engagement with the group that the eligibility criteria aim to regulate; and

c) demonstrates that such disproportionate competitive advantage and/or unpreventable risk exists for the specific sport, discipline and event that the eligibility criteria aim to regulate.

6.2 Should eligibility criteria prevent an athlete from entering a given competition, such athlete should:

a) be allowed to participate in other disciplines and events for which they are eligible, in the same gender category; and

b) be able to contest the ultimate decision of International Federations or other sports organisations through an appropriate internal mediation mechanism, such as ombudsperson, and/or procedures before the Court of Arbitration for Sport, to seek remedy.

7. PRIMACY OF HEALTH AND BODILY AUTONOMY

7.1 Athletes should never be pressured by an International Federation, sports organization, or any other party (either by way of the eligibility criteria or otherwise) to undergo medically unnecessary procedures or treatment to meet eligibility criteria.

7.2 Criteria to determine eligibility for a gender category should not include gynaecological examinations or similar forms of invasive physical examinations, aimed at determining an athlete's sex, sex variations or gender.

7.3 Sports organisations should seek to educate coaches, managers and other members of the entourage to prevent interpretations of their eligibility criteria that can lead to harm.

8. STAKEHOLDER-CENTRED APPROACH

8.1 When drafting, reviewing, evaluating and updating eligibility criteria, sports organisations should meaningfully consult with a cross-section of athletes who may be negatively affected in order to prevent harm.

8.2 Any decisions affecting an athlete's ability to compete should follow the basic standards of procedural fairness, including neutrality and impartiality.

8.3 Sports organisations should put in place internal mechanisms that offer athletes and other affected stakeholders accessible, legitimate, safe and predictable avenues to raise concerns and grievances connected to gender-based eligibility.

9. RIGHT TO PRIVACY

9.1 Sports organisations should ensure transparency in their decision-making processes on eligibility while working to preserve the privacy of individuals who may be affected by such restrictions. This includes all personally identifiable information processed in the context of eligibility decisions which should be handled in compliance with applicable laws and international standards.

9.2 Medical information about an athlete, including testosterone levels, that is collected in the context of anti-doping or otherwise, must be handled in compliance with applicable privacy laws and should be used only for the purposes disclosed to the athlete at the time such information is collected.

International Olympic Committee

9.3 Informed consent should be acquired from athletes prior to the collection of data that is obtained for the purpose of determining eligibility to compete in the men's or women's category.

9.4 Sports organisations should avoid public disclosure of athletes' confidential health and other personal information in the absence of the athlete's consent. In addition, sports organisations should consult with the athletes concerned on the best ways to publicly communicate about their eligibility.

10. PERIODIC REVIEWS

10.1 Eligibility criteria should be subject to predictable periodic review to reflect any relevant ethical, human rights, legal, scientific, and medical developments in this area and should include the affected stakeholder's feedback on their application.

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Lifetime Economic Burden of Intimate Partner Violence Among U.S. Adults

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Abstract

Introduction: This study estimated the U.S. lifetime per-victim cost and economic burden of intimate partner violence.

Methods: Data from previous studies were combined with 2012 U.S. National Intimate Partner and Sexual Violence Survey data in a mathematical model. Intimate partner violence was defined as contact sexual violence, physical violence, or stalking victimization with related impact (e.g., missed work days). Costs included attributable impaired health, lost productivity, and criminal justice costs from the societal perspective. Mean age at first victimization was assessed as 25 years. Future costs were discounted by 3%. The main outcome measures were the mean per-victim (female and male) and total population (or economic burden) lifetime cost of intimate partner violence. Secondary outcome measures were marginal outcome probabilities among victims (e.g., anxiety disorder) and associated costs. Analysis was conducted in 2017.

Results: The estimated intimate partner violence lifetime cost was $103,767 per female victim and $23,414 per male victim, or a population economic burden of nearly $3.6 trillion (2014 US$) over victims' lifetimes, based on 43 million U.S. adults with victimization history. This estimate included $2.1 trillion (59% of total) in medical costs, $1.3 trillion (37%) in lost productivity among victims and perpetrators, $73 billion (2%) in criminal justice activities, and $62 billion (2%) in other costs, including victim property loss or damage. Government sources pay an estimated $1.3 trillion (37%) of the lifetime economic burden.

Conclusions: Preventing intimate partner violence is possible and could avoid substantial costs. These findings can inform the potential benefit of prioritizing prevention, as well as evaluation of implemented prevention strategies.

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SUPPLEMENTAL MATERIAL

Supplemental materials associated with this article can be found in the online version at doi:10.1016/j.amepre.2018.04.049.

INTRODUCTION

In 2012, an estimated 26% of U. S. women and 10% of men reported their lives had been impacted (e.g., missed work or post-traumatic stress disorder [PTSD] symptoms) by contact sexual violence, physical violence, or stalking by an intimate partner.[1] Even more adults reported other forms of intimate partner violence (IPV), including noncontact sexual violence and psychological aggression.[1] IPV victimization is associated with poor short- and long-term physical and mental health outcomes.[2–4]

Few studies have quantified the IPV per-victim cost, which at a minimum includes victims' impaired health, lost productivity, and criminal justice costs,[5,6] and no study has addressed victims' long-term health costs. A 1995 National Violence Against Women analysis estimated the cost of IPV limited to acute and short-term follow-up medical costs and included only female victims ($838 per rape, $816 per physical assault, and $294 per stalking victimization [1995 US$][6]; or, $1,210, $1,178, and $424 as 2014 US$[7]). Following the methodology and presentation of a recent study that estimated the per-person lifetime cost of rape,[8] this study aims to combine previous studies' data with current administrative and surveillance data to estimate the U.S. per-victim lifetime cost and population economic burden of IPV.

METHODS

Study Sample

Mathematical model inputs included: number of U.S. adults (aged ≥ 18 years) with any lifetime and past 12 months IPV exposure, selected attributable, or marginal, health and other outcomes associated with IPV from administrative data and previous studies, and the marginal cost of those outcomes. Marginal outcome refers to the proportion of victims with an outcome beyond the proportion among nonvictims, and is used to calculate the attributable cost of IPV.

The main outcome measures were: (1) lifetime IPV cost per victim, and (2) lifetime IPV cost in the U.S. population (or economic burden) of currently non-institutionalized adults (hereafter, U.S. population), calculated as the lifetime cost per victim multiplied by the estimated victim population. Medical, lost productivity, and criminal justice costs were included. This analysis used the societal cost perspective (i.e., all payers), a lifetime time horizon, and assumed first IPV victimization occurred at victim average age of 25 years.[9] Future costs were discounted by 3%.[10] Costs are presented as 2014 US$ unless otherwise noted, inflated using selected indices.[7,11] Analysis was conducted in 2017 using publicly available data.

Measures

The economic burden is based on the 2012U. S. National Intimate Partnerand Sexual Violence Survey (NISVS) estimated number of males and females with lifetime IPV exposure, defined as contact sexual violence, physical violence, or stalking by an intimate partner and related impact[1] (Table 1, Appendix Tables 1–5, available online, report expanded data and calculations). Contact sexual violence included rape, being made to penetrate,

sexual coercion, and unwanted sexual contact. Physical violence included being slapped, pushed, hit, kicked, hurt by pullinghair, slammed against something, attempting to hurt by choking or suffocating, beaten, burned on purpose, or a perpetrator using a knife or gun. Stalking included repeated harassing or threatening behaviors (e.g., watch-ing, following, orcontacting), causing the victim to be very fearful or concerned for safety; IPV-related impacts included being fear-ful; concerned for safety; PTSD symptoms; injury; needing medi-calcare; contracting sexually transmitted infection (STI); becoming pregnant; need for housing, advocate, or legal services; missing ≥1 day of work or school; or contactingacris is hotline.

IPV outcomes, identified through a targeted literature search, were included based on reference studies' U.S. population representativeness and study design (Appendix Table 3, available online). Studies addressing female and male victims were priori-tized. Reported outcomes had to facilitate calculation of victims' marginal probability of the outcome; for example, outcome prevalence among non-victims and an AOR of the relationship between the outcome and respondents' IPV exposure, controlling for relevant factors.[44] Studies that aligned with this study's exposure definition were prioritized. Unit costs represented the attributable cost of analyzed outcomes based on direct comparison of affected and unaffected individuals (Appendix Table 4, available online). Comprehensive lifetime unit costs that included medical care and lost work productivity and controlled for related conditions (e.g., depression and anxiety) were prioritized. Some lifetime costs were estimated from annual costs by multiplying the annual cost over the age range of respondents in the cost reference study, bounded by this study's average age at first victimization (25 years)[9] and current population life expectancy (79 years[45]; Appendix Table 5, available online). Prevention costs were excluded whenever possible.

A previous NISVS analysis limited to short-term lost productivity costs reported that female and male victims of IPV, sexual violence, or stalking each lost days from school and work valued at $1,063 (females) and $357 (males) (Table 1).[9] Average annual data from 2006–2015 National Crime Victimization Survey indicated 15.3% (*n*=137,155 survey-weighted) of IPV victimizations (rape or sexual assault, robbery, aggravated assault, and simple assault) included victim property loss or damage, valued at a mean $1,181 per victimization (applied in this study as per-victim cost, which is an underestimate for victims with multiple victimizations; Table 1; unpublished data, U.S. Department of Justice). Among IPV victimizations (*n*=745,946 female and *n*=151,910 male, surveyed-weighted) from annual average 2006–2015 National Crime Victimization Survey data, 1.9% of female and 0% of male victimizations required treatment for nonfatal injuries in a doctor's office, 6.6% of females and 4.6% of males required treatment in an emergency department, and 0.2% of females and 0.1% of males were admitted as inpatients (all applied as per-victim estimates in this study; Table 1; unpublished data, U.S. Department of Justice). Unit costs were the estimated payment for a doctor's visit[12] and the lifetime medical and lost productivity costs for an emergency department visit or admission for physical assault or sexual assault[13] (Table 1). In 2012, there were an estimated 1,256 murders (992 females, 264 males) perpetrated by intimate partners (Appendix Table 3, available online).[14,15] Unit costs were medical care and lost productivity due to homicide.[13]

A 2010–2012 NISVS analysis indicated 26.2% of females with lifetime IPV vaginal rape exposure had rape-related pregnancy.[17] Data from a study of a convenience sample of females (n=148) seeking a protection order from an intimate partner reported the outcome of IPV rape-related pregnancies (n=32; i. e., 81% live birth, 16% abortion, 3% still born).[16] Unit costs were estimated payments for medical treatment for medically assisted abortion,[19] pregnancy and delivery,[18] and stillborn hospital birth[20] applied to the estimated number of female IPV vaginal rape victims in 2012 NISVS1,[1,16,17,46] (i.e., cost of child-rearing not included; Table 1).

A nationally representative U.S. study of adult (aged ≥ 18 years) married or common law respondents (n=2,254) reported statistically significantly higher prevalence of anxiety disorder (including PTSD) among females but not males who reported victimization by a current intimate partner.[3] A longitudinal study of young adults (n=1,516) assessed the impact of incident dating violence and reported a significantly greater prevalence of depression among females but not males.[22] That study's results are broadly supported by other studies with only female respondents, which did not report data amenable for inclusion in this study's model.[47,48] Unit costs were medical and lost productivity costs for anxiety disorder (including PTSD)[21] and depression[23] (Table 1).

Data from 18 states in the 2005 Behavioral Risk Factor Surveillance System survey (n=70,156 respondents) indicated significantly higher self-reported prevalence of alcohol abuse and smoking, as well as medically diagnosed asthma, coronary heart disease, joint disease, and stroke among females and males aged ≥ 18 years with lifetime exposure to threatened, attempted, or completed physical violence and nonconsensual sex perpetrated by a current or former intimate partner.[4] Unit costs were the estimated lost work productivity value and medical payments for excess alcohol use,[24,25] smoking,[29] asthma,[30] cardiovascular disease,[37–39] and joint pain[36] (Table 1). Another nationally representative U.S. study of adults (aged 18 years), indicated higher self-reported prevalence of recent cannabis use among females and males recently victimized by an intimate partner,[26] assessed here as the medical and lost productivity cost of illicit drug use.[27]

A large random sample of females (n=1,928) aged 18 64 years at one U.S. managed care plan who reported recent IPV-had significantly higher medically diagnosed prevalence of headaches, gastroesophageal reflux, STI, and urinary tract infections[34] (Table 1). Unit costs were the estimated lost work productivity value and medical payments for moderate pain,[36] gastroesophageal reflux,[35] STI,[40–42] and urinary tract infections.[43] Another large survey of females (n=1,152) aged 18 65 years consecutively surveyed at family practice clinics indicated-a higher prevalence of blindness or glaucoma among females with current IPV compared with females with no IPV exposure.[31] Unit costs were the medical[32] and lost productivity[33] cost of blindness and visual impairment.

Similar to a previous study,[8] authors used a top-down accounting approach to estimate the cost of IPV-related criminal justice activities. Authors' annual IPV-related criminal justice expenditure estimate was $5.7 billion (or $80,632 per convicted IPV perpetrator, both as 2012 US$; Table 2 and Appendix Table 2, available online; included in the model as $83,294 in 2014 US$ [Table 1]).[49–60] Department of Justice funding for victims' services

(e.g., transitional housing) at the federal, state, and local levels was included via this method. With this approach authors could not identify the per-victim cost of such services, and it was not feasible to selectively exclude federal grant money that funds IPV prevention programs[61] or civil court proceedings.[62] This approach neither accounts for public criminal justice expenditures outside of dedicated budgets,[63] nor nonpublic expenditures on related activities. Lost productivity because of incarceration was the annual production value of the U.S. non-institutional population[64] multiplied by authors' average estimated number of years IPV perpetrators are incarcerated (2.3 years) (Table 1, Table 2, Appendix Tables 2, 4, and 5, available online).

Statistical Analysis

Authors multiplied the marginal probability of selected outcomes by associated unit costs to estimate the per-person lifetime cost of IPV for females and males. The sex-specific, per-person estimated cost of IPV was multiplied by the estimated number of females and males with lifetime IPV exposure to estimate the total U.S. lifetime economic burden of IPV. Government costs were assessed as total criminal justice costs plus the estimated government share of all medical spending (i.e., 59.8%).[65]

RESULTS

The present-value, per-victim IPV lifetime cost was $81,960, or $3.6 trillion for all victims, based on 32 million U.S. females and 12 million males with any lifetime victimization (Table 1). The per-victim cost was $103,767 for females and $23,414 for males, representing outcomes differences (e.g., rape-related pregnancy) and differences in the proportion of affected victims by sex for particular outcomes (Table 1).

The economic burden estimate included $2.1 trillion (59% of total) in medical costs, $1.3 trillion (37%) in lost productivity among victims and perpetrators, $73 billion (2%) in criminal justice activities, and $62 billion (2%) in other costs, including victim property loss or damage. Government sources pay an estimated $1.3 trillion (37%) of the economic burden (Table 1).

DISCUSSION

The per-victim lifetime cost ($103,767 for females, $23,414 for males) is the estimated cost of IPV exposure. A recent study using NISVS data and similar methods estimated the lifetime per-victim cost of rape, including intimate partner perpetrators, to be $122,461 (2014 US$).[8] Other comparative cost estimates include the lifetime per-victim cost of nonfatal child maltreatment[66] ($210,012 as 2010 US$, or $225,408 as 2014 US$[7]) and smoking[29] ($219,889 for males and $106,050 for females as 2000 US$, or $292,010 and $139,119 as 2014 US$,[7] respectively).

The per-victim estimate could change with new information about victim outcomes or unit costs. Barring substantial changes to the per-victim cost, the lifetime economic burden estimate ($3.6 trillion) will remain relatively stable, as it is based on the number of U.S. adults with lifetime IPV victimization and IPV-related impact; such a large population

experiences modest incremental demographic changes. The estimated number of victims with IPV exposure in the past 12 months (5,244,000 females and 2,150,000 males[1]) had a lesser effect on the economic burden—only through criminal justice and fatalities costs. The economic burden represents costs over adult victims' lifetimes; therefore, it includes costs already experienced among older living adult victims and future costs among younger living adult victims. Although it is unknown what proportion of victims in the previous 12 months were first-time victimizations, applying this study's per-victim cost estimate yields an approximate annual economic burden of $594 billion. A comparative study estimated the annual economic burden of child maltreatment was $124 $585 billion (2010 US$; or $133–$628 billion as 2014 US$[7]).[66]

Limitations

This study used outcome data from observational studies but assumed IPV was the cause of victims' higher observed prevalence of various outcomes; the status of these outcomes as risk factors for, correlates with, or outcomes of IPV is complex.[48] This means if victims and perpetrators experiencing costs related to IPV would have incurred the same costs because of other risk factors, then this study has overstated the cost attributable to IPV. Future longitudinal analysis of IPV and health outcomes might address this issue, along with issues related to timing of IPV exposure and the effects of multiple victimizations. This study did not include non-monetary elements, sometimes presented as intangible costs—a monetized version of victims' pain and suffering.[67] Costs to victims' and perpetrators' friends and families were not included. Costs to employers and insurance companies were not measured. Government costs were underestimated because reduced tax revenue due to victims' lost work productivity was not included.

The lifetime cost of some outcomes was inferred from annual cost data (Appendix Table 5, available online), which is a major limitation; this assumes an accurate distribution of patients at all stages of a particular outcome (i.e., acute, recurring, remission) in reference studies' annual estimates and, when applied to individuals, may overstate lifetime medical costs. For example, the annual cost of depression and other conditions was uniformly applied to affected victims for multiple years. Based on available data, it was not possible to assign costs by victim demographics or time since IPV exposure. The depression cost estimate referred to major depressive disorder, which represents severe depression. Reference cost studies on non-IPV populations were used for unit costs; such populations may differ in demographic distribution from the IPV victim population. This study did not address the possibility that incarcerating perpetrators could result in fewer IPV victims or victimizations.

Health outcomes that could be linked to specific costs were included, though authors did not attempt to assign a cost to increased risk factors (e.g., IPV victims have higher prevalence of activity limitations and HIV risk factors[4,34]). The cost of nonfatal suicide attempts was not included independent of anxiety and depression costs.[48] The model applied a unit cost of illicit drugs to the marginal prevalence of cannabis use among IPV victims; state-based legalization of non-medical cannabis use (first occurred in late 2012) may decrease the applicability of this unit cost for this outcome in future years. This analysis focused on the

prevalence and cost of formally defined health conditions as assessed in previous studies, such as anxiety (including PTSD) defined by the Composite International Diagnostic Interview 2.1.[26] How ever, a much higher proportion of IPV victims have reported individual symptoms of PTSD (e.g., nightmares, feeling numb or detached[1]). Several lost productivity unit estimates included employed respondents only, and valued respondents' productivity using the human capital approach (i.e., lost wages)—rather than value per statistical life approach—which undervalues lost productivity. Several lost productivity estimates from previous studies did not include mortality. Long-term lost productivity among IPV victims not diagnosed with any of the analyzed outcomes was not included.

Discounting assumed victims' mean age at first IPV victimization was 25 years, which underestimates costs among victims with first victimization at less than 25 years and overestimates costs among victims with first victimization at more than 25 years. First victimization occurs in adolescence for some IPV victims.[1] If first IPV exposure age was instead 18 years, the estimated lifetime cost would increase (per victim: female=$104,238, male=$24,298; data not shown). At an alternative 7% discount rate, the present value cost per victim would be lower (female=$73,378, male=$19,812; data not shown).

Too few reference studies met quality and reporting criteria for a meaningful deterministic sensitivity analysis (e.g., range test per outcome), and too few reported measures of dispersion for a meaningful probabilistic sensitivity analysis (e.g., distribution test based on CIs; Appendix Table 3, available online). Identifiable cost double-counting includes: HIV costs appear in both STI and illicit drug use unit costs, and some anxiety and substance use costs are included in the depression cost (Appendix Tables 3 and 4, available online). A small portion of the illicit drug and excess alcohol unit costs comprised research and prevention activities.[24,25,27,28] Some reference studies focused on outcomes among adults who experienced current or recent IPV or recent outcomes (e.g., STI) rather than lifetime assessment (Appendix Table 3, available online). The short-term lost productivity estimate included lifetime stalking and sexual violence victimizations by non-intimate partners.[9]

This study is notably limited by inexact timelines related to intimate partner victimizations during victims' lifetimes, number of victimizations per victim, number of victims per perpetrator, onset of attributable health outcomes, and treatment of those outcomes and related conditions. This study's acute cost estimates (e.g., short-term medical care) are per victim, rather than per victimization, which underestimates consequences among victims with multiple victimizations.[68] Owing to available data, this study did not address costs among specific subpopulations of IPV victims, including men who have sex with men. This study did not include IPV effects on non-rape pregnancies (e.g., higher prevalence of preterm birth[69]) or on children exposed to IPV (e.g., child abuse and neglect[70]) because population prevalence data are lacking.[71] Some health outcomes measured to be more prevalent among female victims have not been assessed among male victims (e.g., blindness).

CONCLUSIONS

Despite limitations, this study's estimate of IPV per-victim lifetime cost ($103,767 for females, $23,414 for males) included more comprehensive information on victims' lifetime mental and physical health compared with previous estimates and provides IPV cost estimates by impact category. Findings on the cost of IPV can support the need for prevention programs and inform intervention evaluations, identifying cost-effective approaches to eliminate IPV and its substantial impact on public health and public safety. The Centers for Disease Control and Prevention's technical packages help communities use the best available evidence on strategies to stop sexual partner violence and IPV before it starts, including prevention efforts among adolescents and young adults, and support survivors to lessen harms.[72,73]

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Cora Peterson led the study design and interpretation of results, led data analysis, drafted and edited the manuscript, and approved the final manuscript as submitted. Megan C. Kearns conceptualized the study design, managed the literature review to inform the analyses, assisted with study design and interpretation of results, drafted and edited the manuscript, and approved the final manuscript as submitted. Wendy L. McIntosh managed the literature review to inform the analyses, assisted with study design and interpretation of results, drafted and edited the manuscript, and approved the final manuscript as submitted. Lianne Fuino Estefan managed the literature review to inform the analyses, assisted with study design and interpretation of results, drafted and edited the manuscript, and approved the final manuscript as submitted. Christina Nicolaidis led the literature review to inform the analyses, assisted with the study design and interpretation of results, edited the manuscript, and approved the final manuscript as submitted. Kathryn E. McCollister led the literature review to inform the analyses, assisted with the study design and interpretation of results, edited the manuscript, and approved the final manuscript as submitted. Amy Gordon assisted with the study design and interpretation of results, assisted with the literature review to inform the analyses, edited the manuscript, and approved the final manuscript as submitted. Curtis Florence assisted with the study design and interpretation of results, drafted and edited the manuscript, and approved the final manuscript as submitted.

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Table 1.

Outcomes and Costs of IPV Per Victim and U.S. Population (2014 US$)

Measure	Marginal outcome among victims[a,b]		Marginal lifetime cost per outcome, $[c]	Lifetime cost, $[d] Per victim			
	Females	Males		Females	Males	Population	% of total
Total[e]							
Victims[f]	*n*=31,598,000[1]	*n*=11,769,000[1]	81,960	103,767	23,414	3,554,379,074,198	100.00
Medical cost	—	—	48,690	65,165	4,458	2,091,167,801,520	58.8
Lost productivity cost	—	—	30,156	36,065	14,291	1,328,157,006,028	37.4
Criminal justice cost	—	—	1,680	1,376	2,497	72,854,951,254	2.0
Other[g]	—	—	1,434	1,161	2,168	62,199,315,396	1.7
Government cost as % of total	—	—	30,865	40,389	5,294	1,326,323,457,095	37.3
Acute outcomes							
Victim property loss/damage	15.3[h]		1,181[g]	180	180	7,821,902,886	0.2
Victim short-term lost productivity	100.0	100.0	730[9]	1,063	357	37,787,735,510	1.1
Injuries treated by location	—	—	—	1,553	1,026	61,161,905,372	1.7
Doctor's office	1.9[h]	0[h]	168[12]	3	0	100,426,284	0.0
ED treat-and-release	6.6[h]	4.6[h]	7,053	469	323	18,619,253,405	0.5
Medical	—	—	2,860[13]	190	131	7,551,939,243	0.2
Lost productivity	—	—	4,192[13]	279	192	11,067,314,162	0.3
Hospitalization	0.2[h]	0.1[h]	157,658	306	190	11,911,486,138	0.3
Medical	—	—	30,871[13]	60	60	2,600,906,583	0.1
Lost productivity	—	—	126,787[13]	246	130	9,310,579,555	0.3
Victim fatalities	0.02[14,15]	0.01[14,15]	1,671,227	316	205	12,404,636,131	0.3
Medical	—	—	11,707[13]	2	1.44	86,894,883	0.0
Lost productivity	—	—	1,659,520[13]	314	204	12,317,741,248	0.3
Rape-related pregnancy	—	—	—	770	0	24,316,192,319	0.7
Birth	4.6[1,16,17,46]	NA	15,867[18]	734	0	23,208,451,647	0.7

Measure	Marginal outcome among victims[a,b]		Marginal lifetime cost per outcome, $[c]	Lifetime cost, $[d] Per victim			
	Females	Males		Females	Males	Population	% of total
Abortion	0.9[1,16,17,46]	NA	518[19]	5	0	149,578,053	0.0
Stillbirth	0.2[1,16,17,46]	NA	17,687[18,20]	30	0	958,162,619	0.0
Long-term outcomes							
Victim mental health	—	—	—	56,837	0	1,795,944,335,055	50.5
Anxiety disorder (including PTSD)	9.1[3]	0[3]	70,283	6,388	0	201,848,962,281	5.7
Medical	—	—	62,295[21]	5,662	0	178,907,708,598	5.0
Lost productivity	—	—	7,988[21]	726	0	22,941,253,683	0.6
Depression	15.3[22]	0[22]	328,788	50,449	0	1,594,095,372,774	44.8
Medical	—	—	153,906[23]	23,615	0	746,197,091,989	21.0
Lost productivity	—	—	174,882[23]	26,834	0	847,898,280,785	23.9
Victim substance use	—	—	—	7,683	17,254	445,823,059,179	12.5
Alcohol abuse	2.9[4]	7.3[4]	18,317	532	1,342	32,615,553,466	0.9
Medical	—	—	2,081[24,25]	60	153	3,705,786,354	0.1
Lost productivity	—	—	13.176[24,25]	383	966	23,460,634,936	0.7
Other	—	—	3,060[24,25]	89	224	5,449,132,176	0.2
Illicit drug use	0.9[26]	2.6[26]	208,355	1,809	5,344	120,052,305,766	3.4
Medical	—	—	12.737[27,28]	111	327	7,338,707,792	0.2
Lost productivity	—	—	129,533[27,28]	1,125	3,322	74,635,871,014	2.1
Other	—	—	66,085[27,28]	574	1,695	38,077,726,961	1.1
Smoking	10.6[4]	10.2[4]	80,782	5,342	10,567	293,155,199,947	8.2
Medical	—	—	5,427[29]	359[i]	710[i]	19,695,870,448	0.6
Lost productivity	—	—	61,872[29]	4,091[i]	8,093[i]	224,531,049,165	6.3
Other	—	—	13,483[29]	892[i]	1,764[i]	48,928,280,335	1.4
Victim physical health	—	—	—	34,216	2,475	1,110,298,477,848	31.2
Asthma	3.5[4]	1.9[4]	90,150	3,173	1,670	119,922,014,198	3.4
Medical	—	—	82,688[30]	2,910	1,532	109,995,506,175	3.1
Lost productivity	—	—	7,462[30]	263	138	9,926,508,023	0.3

Measure	Marginal outcome among victims[a,b]		Marginal lifetime cost per outcome, $[c]	Lifetime cost, $[d] Per victim			
	Females	Males		Females	Males	Population	% of total
Blindness or glaucoma	1.9[31]	NR	495,731	9,320	0	294,495,270,353	8.3
Medical	—	—	30.132[32]	566	0	17,900,245,166	0.5
Lost productivity	—	—	465,599[33]	8,754	0	276,595,025,187	7.8
Gastroesophageal reflux disease	4.4[34]	NR	15,886	700	0	22,126,987,748	0.6
Medical	—	—	15,223[35]	671	0	21,203,709,288	0.6
Lost productivity	—	—	663[35]	29	0	923,278,459	0.0
Headache	7.0[34]	NR	84,375	5,867	0	185,399,330,079	5.8
Medical	—	—	46.017[36]	3,200	0	101,113,331,173	2.2
Lost productivity	—	—	38,358[36]	2,667	0	84,285,998,906	2.4
Heart disease	1.2[4]	0.0[4]	611,338	7,407	0	234,060,532,626	6.6
Medical	—	—	576,253[37]	7,119	0	224,940,548,425	6.3
Lost productivity	—	—	23,364[38,39]	289	0	9,119,984,201	0.3
Joint conditions	6.7[4]	4.4[4]	18,220	1,214	805	47,841,993,692	1.3
Medical	—	—	16,049[36]	1,070	709	42,143,572,430	1.2
Lost productivity	—	—	2,170[36]	145	96	5,698,421,262	0.2
Sexually transmitted infections	2.4[34]	NR	1,116	26	0	833,986,814	0.0
Medical	—	—	819[40,41]	19	0	612,168,053	0.0
Lost productivity	—	—	297[42]	7	0	221,818,761	0.0
Stroke	1.0[4]	0.0[4]	611,338	5,699	0	180,070,935,989	5.1
Medical	—	—	576,253[37]	5,481	0	173,176,780,404	4.9
Lost productivity	—	—	35,085[38,39]	218	0	6,894,155,585	0.2
Urinary tract infection	9.2[34]	NR	422	39	0	1,231,234,030	0.0
Medical	—	—	136[43]	13	0	395,815,201	0.0
Lost productivity	—	—	286[43]	26	0	835,418,828	0.0
Convicted perpetrators	—	—	—	1,917	1,917	83,137,022,217	2.3
Criminal justice	1.0[j]		83,294[k]	802	802	34,777,224,293	1.0
Lost productivity	1.0[j]		115,825[l]	1,115	1,115	48,359,797,924	1.4

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Note: Appendix Tables 1–5 (available online) show how data as reported in reference studies were used to calculate data as presented in this table.

[a]Combined marginal outcomes for males and females reflect estimates from studies that controlled for victim sex. Appendix Table 3 (available online) provides details. Intimate partner violence defined as contact sexual violence, physical violence, or stalking by an intimate partner and IPV-related impact.[1]

[b]Values are percentages, unless otherwise indicated.

[c]All marginal costs without references are calculated from other data in the table; for example, category sums.

[d]Per victim cost is marginal outcome probability multiplied by marginal cost. Population cost by outcome is the number of victims by sex multiplied by the per-victim cost. Total per-victim by sex and total population costs are the sum of all per-victim (by sex) and population costs by outcome.

[e]"Total" rows are sum of category costs below; e.g., "victim total cost" is sum of "medical," "productivity," "criminal justice," and "other" cost categories, which each represent sum of subcategories (e.g., "other" category includes property damage/loss) (Appendix Table 1, available online, provides details).

[f]Details of reference studies reported in Appendix Table 3 (available online; outcomes), Appendix Table 4 (available online; costs), and Appendix Table 5 (available online; discounted cost calculations).

[g]Includes victim property damage/loss and "other" costs attributable to smoking and alcohol abuse (Appendix Table 1, available online, provides details).

[h]Unpublished data from the U.S. Department of Justice. Estimate is per victimization, rather than per victim. Appendix Tables 3 and 4 (available online) provide details.

[i]Sex-specific estimates applied (Appendix Tables 1 and 4, available online, provide details).

[j]See Table 2.

[k]This is the per convicted perpetrator lifetime cost reported in Table 2 ($80,632 as 2012 US$) as 2014 US$.

[l]See Appendix Table 4 (available online).

ED, emergency department; IPV, intimate partner violence; NA, not applicable; NR, not reported; PTSD, post-traumatic stress disorder.

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Table 2.

Estimated Criminal Justice Costs Related to IPV Among U.S. Adults (2012 US$)

Measure	Input	Unit cost, $[a]	Attributable to IPV		
			Proportion of total, %	Annual cost, $	Per convicted perpetrator lifetime cost, $
Annual IPV victims					80,632[p]
Females, *n*	5,244,000[1]	—	—	—	—
Males, *n*	2,150,000[1]	—	—	—	—
Total U.S. Government justice system annual spending, $	265,160,340,000[49]	—	—	5,739,944,705[m]	—
Police protection					
Annual spending, $	126,434,125,000[49]	11,283[g]	2.1[k]	2,633,042,810[n]	
Annual arrests, all offenses, *n*	11,205,833[50]	—	—	—	—
Annual arrests, intimate partner perpetrators, *n*	233,366[d]	—	—	—	—
Judicial and legal					
Annual spending, $	57,935,169,000[49]	5,170[h]	2.1[k]	1,206,523,794[n]	
Annual arrests, all offenses, *n*	11,205,833[50]	—	—	—	—
Estimated intimate partner perpetrators, *n*	233,336[d]	—	—	—	—
Annual arrests, murder offense, *n*	10,571[50]	—	—	—	—
Estimated intimate partner perpetrators, *n*	1,256[14,15]	—	—	—	—
Annual arrests, rape offense, *n*	21,007[50]	—	—	—	—
Estimated intimate partner perpetrators, %	7[51]	—	—	—	—
Annual arrests, robbery offense, *n*	94,403[50]	—	—	—	—
Estimated intimate partner perpetrators, %	12[51]	—	—	—	—
Annual arrests, aggravated assault offense, *n*	372,685[50]	—	—	—	—
Estimated intimate partner perpetrators, %	15[51]	—	—	—	—
Annual arrests, simple assault offense, *n*	1,093,258[50]	—	—	—	—
Estimated intimate partner perpetrators, %	15[51]	—	—	—	—
Corrections					

Measure	Input	Unit cost, $[a]	Attributable to IPV: Proportion of total, %	Attributable to IPV: Annual cost, $	Attributable to IPV: Per convicted perpetrator lifetime cost, $
Annual spending, $	80,791,046,000[49]	11,641[i]	1.0[l]	1,900,378,101[o]	—
Total corrections population, *n*[b]	6,940,500[52]	—	—	—	—
Corrections spending per intimate partner perpetrator, $	—	26,969[j]	—	—	—
Convicted intimate partner perpetrators (annual), all offenses, *n*	71,187[e]	—	—	—	—
IPV victims with corrections-sentenced perpetrator, %	1.0[f]	—	—	—	—
Average corrections duration per convicted intimate partner perpetrator, all offenses, years[c]	2.3[e]	—	—	—	—

[a]Unit cost refers to per arrest or person in the corrections population.

[b]Total corrections population refers to individuals in prison, jail, probation, parole, not limited to intimate partner perpetrators. Parole defined in source as a period of conditional supervised release in the community following a prison term.

[c]Estimated corrections duration per IPV perpetrator calculated as the sum of parole, prison, and probation terms for the estimated proportion of selected offense types (murder, rape, robbery aggravated assault, simple assault) committed by intimate partners. Includes estimated years in prison, rather than prison sentence received (Appendix Table 2, available online, provides details).

[d]Calculated from number or proportion of arrests for murder, rape, robbery, aggravated assault, and simple assault estimated as intimate partner perpetrators (e.g., 7% of rape offenses).

[e]Calculations and sources reported in Appendix Table 2 (available online).

[f]Calculated as the estimated annual number of IPV victims (5,244,000 + 2,150,000 = 7,394,000) divided by the estimated number of convicted intimate partner perpetrators (71,187) annually.

[g]Calculated as total annual police protection spending ($126 billion) divided by total annual arrests (11,205,833).

[h]Calculated as total annual judicial and legal spending ($58 billion) divided by total annual arrests (11,205,833).

[i]Calculated as total annual corrections spending ($81 billion) divided by total annual corrections population (6,940,500).

[j]Corrections spending per IPV perpetrator calculated as average annual spending per person in the corrections population ($11,641) multiplied by the estimated average corrections duration per intimate partner violence perpetrator (2.3 years), with annual costs after the first year discounted to present value by 3% (Appendix Table 2, available online, provides details).

[k]Calculated as the estimated number of intimate partner perpetrator arrests (233,336) among total arrests (11,205,833).

[l]Calculated as the estimated annual number of convicted intimate partner perpetrators (71,187) as a proportion of the total annual corrections population (6,940,500).

[m]Calculated as sum of annual police protection, judicial and legal, and corrections spending attributable to IPV.

[n]Calculated as total annual spending by category multiplied by estimated proportion attributable to IPV.

[o] Calculated as estimated annual number of convicted intimate partner perpetrators (71,187) multiplied by total estimated discounted corrections cost per intimate partner perpetrator ($26,969).

[p] Calculated as estimated total annual justice system spending attributable to IPV ($5.7 billion) divided by annual number of convicted intimate partner perpetrators (71,187). IPV, intimate partner violence.

Fast Facts: Preventing Sexual Violence

What is sexual violence?

Sexual violence is sexual activity when consent is not obtained or freely given. It is a serious public health problem in the United States that profoundly impacts lifelong health, opportunity, and well-being. Sexual violence impacts every community and affects people of all genders, sexual orientations, and ages. Anyone can experience or perpetrate sexual violence. The perpetrator of sexual violence is usually someone the survivor knows, such as a friend, current or former intimate partner, coworker, neighbor, or family member. Sexual violence can occur in person, online, or through technology, such as posting or sharing sexual pictures of someone without their consent, or non-consensual sexting.

For more information about sexual violence definitions please see Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0 [2.01 MB, 136 Pages, 508].

For information about child sexual abuse, please see Preventing Child Sexual Abuse.

How big is the problem?

Sexual violence affects millions of people each year in the United States. Researchers know the numbers underestimate this problem because many cases are unreported. Survivors may be ashamed, embarrassed, or afraid to tell the police, friends, or family about the violence. Victims may also keep quiet because they have been threatened with further harm if they tell anyone or do not think anyone will help them. The data shows:

- **Sexual violence is common.** Over half of women and almost 1 in 3 men have experienced sexual violence involving physical contact during their lifetimes. One in 4 women and about 1 in 26 men have experienced completed or attempted rape. About 1 in 9 men were made to penetrate someone during his lifetime. Additionally, 1 in 3 women and about 1 in 9 men experienced sexual harassment in a public place.
- **Sexual violence starts early.** More than 4 in 5 female rape survivors reported that they were first raped before age 25 and almost half were first raped as a minor (i.e., before age 18). Nearly 8 in 10 male rape survivors reported that they were made to penetrate someone before age 25 and about 4 in 10 were first made to penetrate as a minor.
- **Sexual violence disproportionately affects some groups.** Women and racial and ethnic minority groups experience a higher burden of sexual violence. For example, more than 2 in 5 non-Hispanic American Indian or Alaska Native and non-Hispanic multiracial women were raped in their lifetime.
- **Sexual violence is costly.** Recent estimates put the lifetime cost of rape at $122,461 per survivor, including medical costs, lost productivity, criminal justice activities, and other costs.

What are the consequences?

Sexual violence consequences are physical, like bruising and genital injuries, sexually transmitted infections, and pregnancy (for women) and psychological, such as depression, anxiety, and suicidal thoughts.

The consequences may be chronic. Survivors may suffer from post-traumatic stress disorder and experience re-occurring reproductive, gastrointestinal, cardiovascular, and sexual health problems.

Sexual violence is also linked to negative health behaviors. Sexual violence survivors are more likely to smoke, abuse alcohol, use drugs, and engage in risky sexual activity.

The trauma from sexual violence may impact a survivor's employment in terms of time off from work, diminished performance, job loss, or inability to work. These issues disrupt earning power and have a long-term effect on the economic well-being of survivors and their families. Coping and completing everyday tasks after victimization can be challenging. Survivors may have difficulty maintaining personal relationships, returning to work or school, and regaining a sense of normalcy.

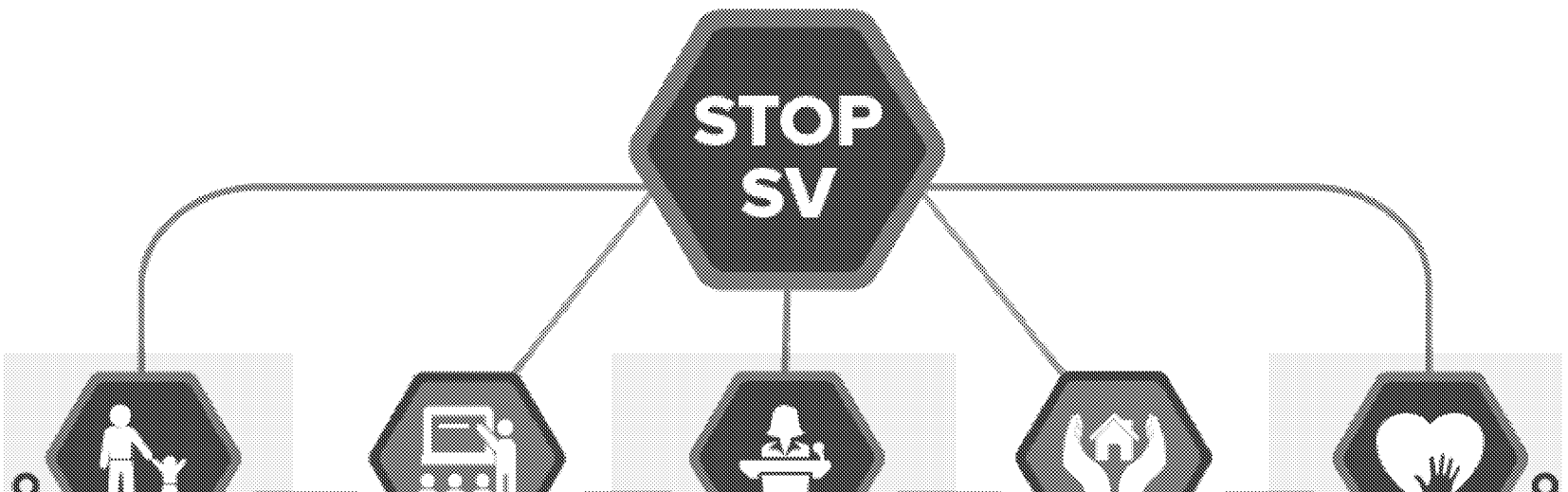
Additionally, sexual violence is connected to other forms of violence. For example, girls who have been sexually abused are more likely to experience additional sexual violence and violence types and become victims of intimate partner violence in adulthood. Bullying perpetration in early middle school is linked to sexual harassment perpetration in high school.

How can we prevent sexual violence?

Certain factors may increase or decrease the risk for perpetrating or experiencing sexual violence. To prevent sexual violence, we must understand and address the factors that put people at risk for or protect them from violence. We must also understand how historical trauma and structural inequities impact health.

CDC developed, STOP SV: A Technical Package to Prevent Sexual Violence [3 MB, 48 Pages, 508] to help communities use the best available evidence to prevent sexual violence. This resource is available in English and Spanish [17MB, 48 Pages, 508] and can impact individual behaviors and relationship, family, school, community, and societal factors that influence risk and protective factors for violence.

Different violence types are connected and often share root causes. Sexual violence is linked to other violence types through shared risk and protective factors. Addressing and preventing one violence type may have an impact on preventing other violence types.



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Page last reviewed: June 22, 2022

U.S. Department of Justice
Civil Rights Division

U.S. Department of Education
Office for Civil Rights

Dear Colleague Letter on Transgender Students
Notice of Language Assistance

If you have difficulty understanding English, you may, free of charge, request language assistance services for this Department information by calling 1-800-USA-LEARN (1-800-872-5327) (TTY: 1-800-877-8339), or email us at: Ed.Language.Assistance@ed.gov.

Aviso a personas con dominio limitado del idioma inglés: Si usted tiene alguna dificultad en entender el idioma inglés, puede, sin costo alguno, solicitar asistencia lingüística con respecto a esta información llamando al 1-800-USA-LEARN (1-800-872-5327) (TTY: 1-800-877-8339), o envíe un mensaje de correo electrónico a: Ed.Language.Assistance@ed.gov.

給英語能力有限人士的通知: 如果您不懂英語，或者使用英语有困难，您可以要求獲得向大眾提供的語言協助服務，幫助您理解教育部資訊。這些語言協助服務均可免費提供。如果您需要有關口譯或筆譯服務的詳細資訊，請致電 1-800-USA-LEARN (1-800-872-5327) (聽語障人士專線：1-800-877-8339),或電郵: Ed.Language.Assistance@ed.gov。

Thông báo dành cho những người có khả năng Anh ngữ hạn chế: Nếu quý vị gặp khó khăn trong việc hiểu Anh ngữ thì quý vị có thể yêu cầu các dịch vụ hỗ trợ ngôn ngữ cho các tin tức của Bộ dành cho công chúng. Các dịch vụ hỗ trợ ngôn ngữ này đều miễn phí. Nếu quý vị muốn biết thêm chi tiết về các dịch vụ phiên dịch hay thông dịch, xin vui lòng gọi số 1-800-USA-LEARN (1-800-872-5327) (TTY: 1-800-877-8339), hoặc email: Ed.Language.Assistance@ed.gov.

영어 미숙자를 위한 공고: 영어를 이해하는 데 어려움이 있으신 경우, 교육부 정보 센터에 일반인 대상 언어 지원 서비스를 요청하실 수 있습니다. 이러한 언어 지원 서비스는 무료로 제공됩니다. 통역이나 번역 서비스에 대해 자세한 정보가 필요하신 경우, 전화번호 1-800-USA-LEARN (1-800-872-5327) 또는 청각 장애인용 전화번호 1-800-877-8339 또는 이메일주소 Ed.Language.Assistance@ed.gov 으로 연락하시기 바랍니다.

Paunawa sa mga Taong Limitado ang Kaalaman sa English: Kung nahihirapan kayong makaintindi ng English, maaari kayong humingi ng tulong ukol dito sa inpormasyon ng Kagawaran mula sa nagbibigay ng serbisyo na pagtulong kaugnay ng wika. Ang serbisyo na pagtulong kaugnay ng wika ay libre. Kung kailangan ninyo ng dagdag na impormasyon tungkol sa mga serbisyo kaugnay ng pagpapaliwanag o pagsasalin, mangyari lamang tumawag sa 1-800-USA-LEARN (1-800-872-5327) (TTY: 1-800-877-8339), o mag-email sa: Ed.Language.Assistance@ed.gov.

Уведомление для лиц с ограниченным знанием английского языка: Если вы испытываете трудности в понимании английского языка, вы можете попросить, чтобы вам предоставили перевод информации, которую Министерство Образования доводит до всеобщего сведения. Этот перевод предоставляется бесплатно. Если вы хотите получить более подробную информацию об услугах устного и письменного перевода, звоните по телефону 1-800-USA-LEARN (1-800-872-5327) (служба для слабослышащих: 1-800-877-8339), или отправьте сообщение по адресу: Ed.Language.Assistance@ed.gov.

U.S. Department of Justice
Civil Rights Division

U.S. Department of Education
Office for Civil Rights

May 13, 2016

Dear Colleague:

Schools across the country strive to create and sustain inclusive, supportive, safe, and nondiscriminatory communities for all students. In recent years, we have received an increasing number of questions from parents, teachers, principals, and school superintendents about civil rights protections for transgender students. Title IX of the Education Amendments of 1972 (Title IX) and its implementing regulations prohibit sex discrimination in educational programs and activities operated by recipients of Federal financial assistance.[1] This prohibition encompasses discrimination based on a student's gender identity, including discrimination based on a student's transgender status. This letter summarizes a school's Title IX obligations regarding transgender students and explains how the U.S. Department of Education (ED) and the U.S. Department of Justice (DOJ) evaluate a school's compliance with these obligations.

ED and DOJ (the Departments) have determined that this letter is *significant guidance*.[2] This guidance does not add requirements to applicable law, but provides information and examples to inform recipients about how the Departments evaluate whether covered entities are complying with their legal obligations. If you have questions or are interested in commenting on this guidance, please contact ED at ocr@ed.gov or 800-421-3481 (TDD 800-877-8339); or DOJ at education@usdoj.gov or 877-292-3804 (TTY: 800-514-0383).

Accompanying this letter is a separate document from ED's Office of Elementary and Secondary Education, *Examples of Policies and Emerging Practices for Supporting Transgender Students*. The examples in that document are taken from policies that school districts, state education agencies, and high school athletics associations around the country have adopted to help ensure that transgender students enjoy a supportive and nondiscriminatory school environment. Schools are encouraged to consult that document for practical ways to meet Title IX's requirements.[3]

Terminology

- *Gender identity* refers to an individual's internal sense of gender. A person's gender identity may be different from or the same as the person's sex assigned at birth.

- *Sex assigned at birth* refers to the sex designation recorded on an infant's birth certificate should such a record be provided at birth.

- *Transgender* describes those individuals whose gender identity is different from the sex they were assigned at birth. A *transgender male* is someone who identifies as male but was assigned the sex of female at birth; a *transgender female* is someone who identifies as female but was assigned the sex of male at birth.

- *Gender transition* refers to the process in which transgender individuals begin asserting the sex that corresponds to their gender identity instead of the sex they were assigned at birth. During gender transition, individuals begin to live and identify as the sex consistent with their gender identity and may dress differently, adopt a new name, and use pronouns consistent with their gender identity. Transgender individuals may undergo gender transition at any stage of their lives, and gender transition can happen swiftly or over a long duration of time.

Compliance with Title IX

As a condition of receiving Federal funds, a school agrees that it will not exclude, separate, deny benefits to, or otherwise treat differently on the basis of sex any person in its educational programs or activities unless expressly authorized to do so under Title IX or its implementing regulations.[4] The Departments treat a student's gender identity as the student's sex for purposes of Title IX and its implementing regulations. This means that a school must not treat a transgender student differently from the way it treats other students of the same gender identity. The Departments' interpretation is consistent with courts' and other agencies' interpretations of Federal laws prohibiting sex discrimination.[5]

The Departments interpret Title IX to require that when a student or the student's parent or guardian, as appropriate, notifies the school administration that the student will assert a gender identity that differs from previous representations or records, the school will begin treating the student consistent with the student's gender identity. Under Title IX, there is no medical diagnosis or treatment requirement that students must meet as a prerequisite to being treated consistent with their gender identity.[6] Because transgender students often are unable to obtain identification documents that reflect their gender identity (*e.g.*, due to restrictions imposed by state or local law in their place of birth or residence),[7] requiring students to produce such identification documents in order to treat them consistent with their gender identity may violate Title IX when doing so has the practical effect of limiting or denying students equal access to an educational program or activity.

A school's Title IX obligation to ensure nondiscrimination on the basis of sex requires schools to provide transgender students equal access to educational programs and activities even in circumstances in which other students, parents, or community members raise objections or concerns. As is consistently recognized in civil rights cases, the desire to accommodate others' discomfort cannot justify a policy that singles out and disadvantages a particular class of students.[8]

1. Safe and Nondiscriminatory Environment

Schools have a responsibility to provide a safe and nondiscriminatory environment for all students, including transgender students. Harassment that targets a student based on gender identity, transgender status, or gender transition is harassment based on sex, and the Departments enforce Title IX accordingly.[9] If sex-based harassment creates a hostile environment, the school must take prompt and effective steps to end the harassment, prevent its recurrence, and, as appropriate, remedy its effects. A school's failure to treat students consistent with their gender identity may create or contribute to a hostile environment in violation of Title IX. For a more detailed discussion of Title IX

requirements related to sex-based harassment, see guidance documents from ED's Office for Civil Rights (OCR) that are specific to this topic.[10]

2. Identification Documents, Names, and Pronouns

Under Title IX, a school must treat students consistent with their gender identity even if their education records or identification documents indicate a different sex. The Departments have resolved Title IX investigations with agreements committing that school staff and contractors will use pronouns and names consistent with a transgender student's gender identity.[11]

3. Sex-Segregated Activities and Facilities

Title IX's implementing regulations permit a school to provide sex-segregated restrooms, locker rooms, shower facilities, housing, and athletic teams, as well as single-sex classes under certain circumstances.[12] When a school provides sex-segregated activities and facilities, transgender students must be allowed to participate in such activities and access such facilities consistent with their gender identity.[13]

- **Restrooms and Locker Rooms**. A school may provide separate facilities on the basis of sex, but must allow transgender students access to such facilities consistent with their gender identity.[14] A school may not require transgender students to use facilities inconsistent with their gender identity or to use individual-user facilities when other students are not required to do so. A school may, however, make individual-user options available to all students who voluntarily seek additional privacy.[15]

- **Athletics.** Title IX regulations permit a school to operate or sponsor sex-segregated athletics teams when selection for such teams is based upon competitive skill or when the activity involved is a contact sport.[16] A school may not, however, adopt or adhere to requirements that rely on overly broad generalizations or stereotypes about the differences between transgender students and other students of the same sex (*i.e.*, the same gender identity) or others' discomfort with transgender students.[17] Title IX does not prohibit age-appropriate, tailored requirements based on sound, current, and research-based medical knowledge about the impact of the students' participation on the competitive fairness or physical safety of the sport.[18]

- **Single-Sex Classes**. Although separating students by sex in classes and activities is generally prohibited, nonvocational elementary and secondary schools may offer nonvocational single-sex classes and extracurricular activities under certain circumstances.[19] When offering such classes and activities, a school must allow transgender students to participate consistent with their gender identity.

- **Single-Sex Schools**. Title IX does not apply to the admissions policies of certain educational institutions, including nonvocational elementary and secondary schools, and private undergraduate colleges.[20] Those schools are therefore permitted under Title IX to set their own

sex-based admissions policies. Nothing in Title IX prohibits a private undergraduate women's college from admitting transgender women if it so chooses.

- **Social Fraternities and Sororities**. Title IX does not apply to the membership practices of social fraternities and sororities.[21] Those organizations are therefore permitted under Title IX to set their own policies regarding the sex, including gender identity, of their members. Nothing in Title IX prohibits a fraternity from admitting transgender men or a sorority from admitting transgender women if it so chooses.

- **Housing and Overnight Accommodations**. Title IX allows a school to provide separate housing on the basis of sex.[22] But a school must allow transgender students to access housing consistent with their gender identity and may not require transgender students to stay in single-occupancy accommodations or to disclose personal information when not required of other students. Nothing in Title IX prohibits a school from honoring a student's voluntary request for single-occupancy accommodations if it so chooses.[23]

- **Other Sex-Specific Activities and Rules**. Unless expressly authorized by Title IX or its implementing regulations, a school may not segregate or otherwise distinguish students on the basis of their sex, including gender identity, in any school activities or the application of any school rule. Likewise, a school may not discipline students or exclude them from participating in activities for appearing or behaving in a manner that is consistent with their gender identity or that does not conform to stereotypical notions of masculinity or femininity (*e.g.*, in yearbook photographs, at school dances, or at graduation ceremonies).[24]

4. Privacy and Education Records

Protecting transgender students' privacy is critical to ensuring they are treated consistent with their gender identity. The Departments may find a Title IX violation when a school limits students' educational rights or opportunities by failing to take reasonable steps to protect students' privacy related to their transgender status, including their birth name or sex assigned at birth.[25] Nonconsensual disclosure of personally identifiable information (PII), such as a student's birth name or sex assigned at birth, could be harmful to or invade the privacy of transgender students and may also violate the Family Educational Rights and Privacy Act (FERPA).[26] A school may maintain records with this information, but such records should be kept confidential.

- **Disclosure of Personally Identifiable Information from Education Records**. FERPA generally prevents the nonconsensual disclosure of PII from a student's education records; one exception is that records may be disclosed to individual school personnel who have been determined to have a legitimate educational interest in the information.[27] Even when a student has disclosed the student's transgender status to some members of the school community, schools may not rely on this FERPA exception to disclose PII from education records to other school personnel who do not have a legitimate educational interest in the information. Inappropriately disclosing (or requiring students or their parents to disclose) PII from education records to the school community may

violate FERPA and interfere with transgender students' right under Title IX to be treated consistent with their gender identity.

- **Disclosure of Directory Information**. Under FERPA's implementing regulations, a school may disclose appropriately designated directory information from a student's education record if disclosure would not generally be considered harmful or an invasion of privacy.[28] Directory information may include a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance.[29] School officials may not designate students' sex, including transgender status, as directory information because doing so could be harmful or an invasion of privacy.[30] A school also must allow eligible students (*i.e.*, students who have reached 18 years of age or are attending a postsecondary institution) or parents, as appropriate, a reasonable amount of time to request that the school not disclose a student's directory information.[31]

- **Amendment or Correction of Education Records**. A school may receive requests to correct a student's education records to make them consistent with the student's gender identity. Updating a transgender student's education records to reflect the student's gender identity and new name will help protect privacy and ensure personnel consistently use appropriate names and pronouns.

  - Under FERPA, a school must consider the request of an eligible student or parent to amend information in the student's education records that is inaccurate, misleading, or in violation of the student's privacy rights.[32] If the school does not amend the record, it must inform the requestor of its decision and of the right to a hearing. If, after the hearing, the school does not amend the record, it must inform the requestor of the right to insert a statement in the record with the requestor's comments on the contested information, a statement that the requestor disagrees with the hearing decision, or both. That statement must be disclosed whenever the record to which the statement relates is disclosed.[33]
  - Under Title IX, a school must respond to a request to amend information related to a student's transgender status consistent with its general practices for amending other students' records.[34] If a student or parent complains about the school's handling of such a request, the school must promptly and equitably resolve the complaint under the school's Title IX grievance procedures.[35]

* * *

We appreciate the work that many schools, state agencies, and other organizations have undertaken to make educational programs and activities welcoming, safe, and inclusive for all students.

Sincerely,

/s/

Catherine E. Lhamon
Assistant Secretary for Civil Rights
U.S. Department of Education

/s/

Vanita Gupta
Principal Deputy Assistant Attorney General for Civil Rights
U.S. Department of Justice

[1] 20 U.S.C. §§ 1681–1688; 34 C.F.R. Pt. 106; 28 C.F.R. Pt. 54. In this letter, the term *schools* refers to recipients of Federal financial assistance at all educational levels, including school districts, colleges, and universities. An educational institution that is controlled by a religious organization is exempt from Title IX to the extent that compliance would not be consistent with the religious tenets of such organization. 20 U.S.C. § 1681(a)(3); 34 C.F.R. § 106.12(a).

[2] Office of Management and Budget, Final Bulletin for Agency Good Guidance Practices, 72 Fed. Reg. 3432 (Jan. 25, 2007), www.whitehouse.gov/sites/default/files/omb/fedreg/2007/012507_good_guidance.pdf.

[3] ED, *Examples of Policies and Emerging Practices for Supporting Transgender Students* (May 13, 2016), www.ed.gov/oese/oshs/emergingpractices.pdf. OCR also posts many of its resolution agreements in cases involving transgender students online at www.ed.gov/ocr/lgbt.html. While these agreements address fact-specific cases, and therefore do not state general policy, they identify examples of ways OCR and recipients have resolved some issues addressed in this guidance.

[4] 34 C.F.R. §§ 106.4, 106.31(a). For simplicity, this letter cites only to ED's Title IX regulations. DOJ has also promulgated Title IX regulations. *See* 28 C.F.R. Pt. 54. For purposes of how the Title IX regulations at issue in this guidance apply to transgender individuals, DOJ interprets its regulations similarly to ED. State and local rules cannot limit or override the requirements of Federal laws. *See* 34 C.F.R. § 106.6(b).

[5] *See, e.g., Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989); *Oncale v. Sundowner Offshore Servs. Inc.*, 523 U.S. 75, 79 (1998); *G.G. v. Gloucester Cnty. Sch. Bd.*, No. 15-2056, 2016 WL 1567467, at *8 (4th Cir. Apr. 19, 2016); *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011); *Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000); *Schwenk v. Hartford*, 204 F.3d 1187, 1201–02 (9th Cir. 2000); *Schroer v. Billington*, 577 F. Supp. 2d 293, 306-08 (D.D.C. 2008); *Macy v. Dep't of Justice*, Appeal No. 012012082 (U.S. Equal Emp't Opportunity Comm'n Apr. 20, 2012). *See also* U.S. Dep't of Labor (USDOL), Training and Employment Guidance Letter No. 37-14, *Update on Complying with Nondiscrimination Requirements: Discrimination Based on Gender Identity, Gender Expression and Sex Stereotyping are Prohibited Forms of Sex Discrimination in the Workforce Development System* (2015), wdr.doleta.gov/directives/attach/TEGL/TEGL_37-14.pdf; USDOL, Job Corps, Directive: Job Corps Program Instruction Notice No. 14-31, *Ensuring Equal Access for Transgender Applicants and Students to the Job Corps Program* (May 1, 2015), https://supportservices.jobcorps.gov/Program%20Instruction%20Notices/pi_14_31.pdf; DOJ, Memorandum from the Attorney General, *Treatment of Transgender Employment Discrimination Claims Under Title VII of the Civil Rights Act of 1964* (2014), www.justice.gov/sites/default/files/opa/press-releases/attachments/2014/12/18/title_vii_memo.pdf; USDOL, Office of Federal Contract Compliance Programs, Directive 2014-02, *Gender Identity and Sex Discrimination* (2014), www.dol.gov/ofccp/regs/compliance/directives/dir2014_02.html.

[6] *See Lusardi v. Dep't of the Army*, Appeal No. 0120133395 at 9 (U.S. Equal Emp't Opportunity Comm'n Apr. 1, 2015) ("An agency may not condition access to facilities—or to other terms, conditions, or privileges of employment—on the completion of certain medical steps that the agency itself has unilaterally determined will somehow prove the bona fides of the individual's gender identity.").

[7] *See G.G.*, 2016 WL 1567467, at *1 n.1 (noting that medical authorities "do not permit sex reassignment surgery for persons who are under the legal age of majority").

[8] 34 C.F.R. § 106.31(b)(4); *see G.G.*, 2016 WL 1567467, at *8 & n.10 (affirming that individuals have legitimate and important privacy interests and noting that these interests do not inherently conflict with nondiscrimination principles); *Cruzan v. Special Sch. Dist. No. 1*, 294 F.3d 981, 984 (8th Cir. 2002) (rejecting claim that allowing a transgender woman "merely [to be] present in the women's faculty restroom" created a hostile environment); *Glenn*, 663 F.3d at 1321 (defendant's proffered justification that "other women might object to [the plaintiff]'s restroom use" was "wholly irrelevant"). *See also Palmore v. Sidoti*, 466 U.S. 429, 433 (1984) ("Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect."); *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 448 (1985) (recognizing that "mere negative attitudes, or fear . . . are not permissible bases for" government action).

[9] *See, e.g.,* Resolution Agreement, *In re Downey Unified Sch. Dist., CA*, OCR Case No. 09-12-1095, (Oct. 8, 2014), www.ed.gov/documents/press-releases/downey-school-district-agreement.pdf (agreement to address harassment of transgender student, including allegations that peers continued to call her by her former name, shared pictures of her prior to her transition, and frequently asked questions about her anatomy and sexuality); Consent Decree, *Doe v. Anoka-Hennepin Sch. Dist. No. 11, MN* (D. Minn. Mar. 1, 2012), www.ed.gov/ocr/docs/investigations/05115901-d.pdf (consent decree to address sex-based harassment, including based on nonconformity with gender stereotypes); Resolution Agreement, *In re Tehachapi Unified Sch. Dist., CA*, OCR Case No. 09-11-1031 (June 30, 2011), www.ed.gov/ocr/docs/investigations/09111031-b.pdf (agreement to address sexual and gender-based harassment, including harassment based on nonconformity with gender stereotypes). *See also Lusardi,* Appeal No. 0120133395, at *15 ("Persistent failure to use the employee's correct name and pronoun may constitute unlawful, sex-based harassment if such conduct is either severe or pervasive enough to create a hostile work environment").

[10] *See, e.g.*, OCR, *Revised Sexual Harassment Guidance: Harassment of Students by School Employees, Other Students, or Third Parties* (2001), www.ed.gov/ocr/docs/shguide.pdf; OCR, *Dear Colleague Letter: Harassment and Bullying* (Oct. 26, 2010), www.ed.gov/ocr/letters/colleague-201010.pdf; OCR, *Dear Colleague Letter: Sexual Violence* (Apr. 4, 2011), www.ed.gov/ocr/letters/colleague-201104.pdf; OCR, *Questions and Answers on Title IX and Sexual Violence* (Apr. 29, 2014), www.ed.gov/ocr/docs/qa-201404-title-ix.pdf.

[11] *See, e.g.*, Resolution Agreement, *In re Cent. Piedmont Cmty. Coll., NC*, OCR Case No. 11-14-2265 (Aug. 13, 2015), www.ed.gov/ocr/docs/investigations/more/11142265-b.pdf (agreement to use a transgender student's preferred name and gender and change the student's official record to reflect a name change).

[12] 34 C.F.R. §§ 106.32, 106.33, 106.34, 106.41(b).

[13] *See* 34 C.F.R. § 106.31.

[14] 34 C.F.R. § 106.33.

[15] *See, e.g.*, Resolution Agreement, *In re Township High Sch. Dist. 211, IL*, OCR Case No. 05-14-1055 (Dec. 2, 2015), www.ed.gov/ocr/docs/investigations/more/05141055-b.pdf (agreement to provide any student who requests additional privacy "access to a reasonable alternative, such as assignment of a student locker in near proximity to the office of a teacher or coach; use of another private area (such as a restroom stall) within the public area; use of a nearby private area (such as a single-use facility); or a separate schedule of use.").

[16] 34 C.F.R. § 106.41(b). Nothing in Title IX prohibits schools from offering coeducational athletic opportunities.

[17] 34 C.F.R. § 106.6(b), (c). An interscholastic athletic association is subject to Title IX if (1) the association receives Federal financial assistance or (2) its members are recipients of Federal financial assistance and have ceded controlling authority over portions of their athletic program to the association. Where an athletic association is covered by Title IX, a school's obligations regarding transgender athletes apply with equal force to the association.

[18] The National Collegiate Athletic Association (NCAA), for example, reported that in developing its policy for participation by transgender students in college athletics, it consulted with medical experts, athletics officials, affected students, and a consensus report entitled *On the Team: Equal Opportunity for Transgender Student Athletes* (2010) by Dr. Pat Griffin & Helen J. Carroll (*On the Team*), https://www.ncaa.org/sites/default/files/NCLR_TransStudentAthlete%2B(2).pdf. *See* NCAA Office of Inclusion, *NCAA Inclusion of Transgender Student-Athletes* 2, 30-31 (2011), https://www.ncaa.org/sites/default/files/Transgender_Handbook_2011_Final.pdf (citing *On the Team*). The *On the Team* report noted that policies that may be appropriate at the college level may "be unfair and too complicated for [the high school] level of competition." *On the Team* at 26. After engaging in similar processes, some state interscholastic athletics associations have adopted policies for participation by transgender students in high school athletics that they determined were age-appropriate.

[19] 34 C.F.R. § 106.34(a), (b). Schools may also separate students by sex in physical education classes during participation in contact sports. *Id.* § 106.34(a)(1).

[20] 20 U.S.C. § 1681(a)(1); 34 C.F.R. § 106.15(d); 34 C.F.R. § 106.34(c) (a recipient may offer a single-sex public nonvocational elementary and secondary school so long as it provides students of the excluded sex a "substantially

equal single-sex school or coeducational school").

[21] 20 U.S.C. § 1681(a)(6)(A); 34 C.F.R. § 106.14(a).

[22] 20 U.S.C. § 1686; 34 C.F.R. § 106.32.

[23] *See, e.g.*, Resolution Agreement, *In re Arcadia Unified. Sch. Dist., CA*, OCR Case No. 09-12-1020, DOJ Case No. 169-12C-70, (July 24, 2013), www.justice.gov/sites/default/files/crt/legacy/2013/07/26/arcadiaagree.pdf (agreement to provide access to single-sex overnight events consistent with students' gender identity, but allowing students to request access to private facilities).

[24] *See* 34 C.F.R. §§ 106.31(a), 106.31(b)(4). *See also*, *In re Downey Unified Sch. Dist., CA*, *supra* n. 9; *In re Cent. Piedmont Cmty. Coll., NC, supra* n. 11.

[25] 34 C.F.R. § 106.31(b)(7).

[26] 20 U.S.C. § 1232g; 34 C.F.R. Part 99. FERPA is administered by ED's Family Policy Compliance Office (FPCO). Additional information about FERPA and FPCO is available at www.ed.gov/fpco.

[27] 20 U.S.C. § 1232g(b)(1)(A); 34 C.F.R. § 99.31(a)(1).

[28] 34 C.F.R. §§ 99.3, 99.31(a)(11), 99.37.

[29] 20 U.S.C. § 1232g(a)(5)(A); 34 C.F.R. § 99.3.

[30] Letter from FPCO to Institutions of Postsecondary Education 3 (Sept. 2009), www.ed.gov/policy/gen/guid/fpco/doc/censuslettertohighered091609.pdf.

[31] 20 U.S.C. § 1232g(a)(5)(B); 34 C.F.R. §§ 99.3. 99.37(a)(3).

[32] 34 C.F.R. § 99.20.

[33] 34 C.F.R. §§ 99.20-99.22.

[34] *See* 34 C.F.R. § 106.31(b)(4).

[35] 34 C.F.R. § 106.8(b).

List of Citations for Administrative Record
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- 5 U.S.C. § 552
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- 20 U.S.C. § 1070a
- 20 U.S.C. § 1092 - Institutional and Financial Assistance Information for Students
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- 20 U.S.C. § 1221e-3 - General Authority of Secretary
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- 20 U.S.C. § 1401 – Definitions
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- 26 C.F.R. § 38
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- 34 C.F.R. § 668.46 Institutional Security Policies and Crime Statistics
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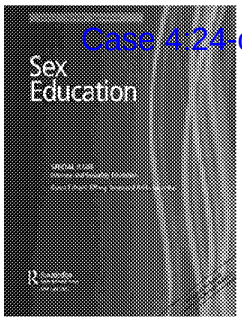

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Intersex students, sex-based relational learning & isolation

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ABSTRACT

Stigma is an important contributor to social isolation and has negative wellbeing and health impacts. People with intersex variations experience stigma based on multiple factors – family-based silencing and stigma; lack of adequate puberty education normalising body diversity at school; and medically imposed stigma from 'corrective' interventions. This article outlines theory concerning sex-based relational socialisation in schools for friendships and other relationships. It explores the literature on social isolation and exclusion and on students with intersex variations. It reports on the sex-based relational learning informed by the schooling experiences of 86 people with intersex variations aged 22–71 years, recruited from diverse international contexts. Students with intersex variations desired friendships with students of a different assigned sex more frequently than did endosex students. They had different friendship and dating patterns and greater experience of social isolation compared to endosex students in both primary/elementary and high/secondary school contexts. Almost all participants found surgical intervention to be inappropriate and the inappropriateness of the gender in which they are brought up was a strong predictor of negative sex-based relational learning experiences and social isolation. Data provide important arguments for young people with intersex variations to have greater bodily, sex and gender determining autonomy in school and related settings.

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Introduction

Intersex is an umbrella term used to describe individuals born with medically 'atypical' sex characteristics: whether these be anatomical, hormonal and/or chromosomal variations (Jones 2017). Intersex-led advocacy groups define intersex variations broadly, including variations affecting other primary and/or secondary sex characteristics and thus social and institutional experiences in ways relevant to rights advocacy.

This paper understands 'sex' as being the human interpretation of bodies' primary and/or secondary sex anatomical characteristics (internal and external genitalia but also gonads, height, hair, muscle and fat distribution etc), hormones and/or chromosomes used with respect to assignments such as male/M, female/F, other/X). 'Gender', in contrast, is framed in terms of social roles and identities, including feminine, masculine and non-binary forms of expression. Both 'endosex' (an intersex-led advocacy term for people whose sex traits are

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medically 'typical/dyadic') and intersex individuals may be cisgender (gender aligns with assigned sex), transgender (gender differs) or of any sexual orientation (Feder 2009).

A review of the international research on people with intersex variations found ittended to focus strongly on medical and health issues in north-American contexts using Western medical or, more recently, critical lenses, Henningham et al (2017). Specifically educational studies were rare (Jones 2018). This paper considers school-based socialisation for people with intersex variations internationally with an emphasis on relational (rather than medical) matters concerning sex traits learned experientially in schooling. It begins by outlining theory relating to sex-based relational socialisation in schools, then discusses the literature on social isolation and students with intersex variations. Finally, it reports on findings from a survey which retrospectively explored intersex students' experiences of school-based socialisation.

Theorising sex-based relational socialisation in school

Sociological and psychological theory from Australian (Jones 2020) and German (Jürgensen et al. 2010) sources argues that young people learn sex-based relational roles at school through both the direct and hidden school curriculum as they relate to sex and puberty. In both conservative and liberal schools, the ideologically dominant types of school world-wide, students generally learn that friendship is to be formed with people of the same sex (Apple 2006; Jones 2020; Kemmis, Cole, and Suggett 1983). A conservative schooling approach often promotes a sex segregationist stance which manifests in single-sex schooling and sex-differentiated learning (e.g. home-economics for female students vs. vocational learning for males), extra-curricular/sports (e.g. male-only football leagues) and grouping or lining-up practices (Jones 2020). A liberal schooling approach is associated with more indirect learning about same-sex friendship preferences through default choice and gender subjection. Although same-sex friendships are not 'enforced', studying with and learning from people of the same sex in similar subject areas and with similar attire is implicitly rewarded through social approval (Jones 2020; Jürgensen et al. 2010; Tait 2019; Ullman 2017).

Beyond this, students generally learn that gendered behaviour is necessary to maintain same-sex friendships, from the normalisation of gendered activities through to outright policing and bullying (Jürgensen et al. 2010; Tait 2019). Additionally, in both conservative and liberal schools, students learn that dating and sexual relationships are to take place with people of an 'opposite' sex in line with a two-sex binary model. Conservative schools may directly teach that heteronormative procreative marriage as a goal, based on religious expectations or other reasoning (Elia and Eliason 2010; Jones 2020) while more progressive schools may achieve the same goal simply by overlooking alternatives (Ferfolja and Ullman 2017; Irvine 2002; Kondakov 2013; Rasmussen 2006). As a result, students who desire or experience romantic or sexual relationships beyond heteronormative expectations may feel alone or isolated.

Social isolation

Nearly half of 20,000 participants in a recent US study reported sometimes or always feeling alone and 40% felt isolated (Cigna 2018). When social isolation and loneliness are

frequent, chronic and involuntarily imposed, they can impact wellbeing and health (Holt-Lunstad et al. 2015; Sutin et al. 2018). A recent meta-analysis found that lack of social connection heightens health risks as much as smoking or alcohol use disorders, and that loneliness and social isolation are twice as harmful to physical and mental health as obesity (Holt-Lunstad et al. 2015). Furthermore, an absence of social relationships and behaviours may affect later development (Lacey, Kumari, and Bartley 2014; Makinodan et al. 2012).

Socially isolated children tend to have lower educational attainment, be part of a less advantaged social class in adulthood and are more likely to be psychologically distressed as adults (Lacey, Kumari, and Bartley 2014). A major cause of social isolation is stigma due to difference or disability and the attending awkwardness that others or the stigmatised individual may feel about it (Biordi and Nicholson 2013). These forms of stigma are experienced by people with intersex variations due to a lack of understanding and/or acceptance of bodily diversity.

People with intersex variations experience negative responses in many facets of life. This includes family-based silencing about inherited sex differences and familial stigma (Jones 2017); poor quality puberty education at school which can stigmatise sex traits beyond those discussed (Jones 2016); and medically imposed stigma that creates the pressure to conform to sex norms that one does not fit (Davis 2015; Sanders and Carter 2015). The inclusive education movement has proactively sought to combat social isolation and stigmatisation for LGBTI students broadly (Badgett et al. 2014; Poteat et al. 2017; UNESCO 2015). However, relatively little research considers people with intersex variations' social sex-based learning.

School experience as an intersex student

Educational research is growing on people with intersex variations (Bromdal et al. 2016; Jones 2016; Sanders and Carter 2015) and their experience during the schooling years (Jürgensen et al. 2010; Lux et al. 2009). Studies to date have predominantly taken place in contexts such as Australia, Germany, New Zealand, North America and the UK. Bromdal et al. (2016), for example, consider how myths and ignorance about human sex result in intersex bodies inhabiting the space of the 'embarrassing other' in Australian and New Zealand school sexuality education. They assert that the 'norm' creating technologies of medical and educational institutions regulate intersex bodies and call for educators to discuss intersex in terms of how power comes to accrue to particular bodies. A small UK study of young intersex women documented participants' uncertainty, confusion and insecurity about how they fitted into identity and friendship circles (Sanders and Carter 2015). Participants wanted to enjoy secure and safe friendships and relationships, but remained guarded about their intersex variation(s) in order to prevent bullying.

Other school experiences have been looked at by Jones (2016) and Jürgensen et al. (2010). Jones (2016) found that 75% of Australian intersex students were bullied during school; however, most of the bullying occurred over participants' physical difference as the result of (undisclosed) intersex variations, not perpetrators' knowledge of participants having intersex variations. In the same study, 46% of intersex students experienced depression or had thoughts of suicide while only 24% reported having a positive experience of schooling. Intersex students called for better bullying prevention policy and more

staff intervention and school support if they were attacked (Jones 2016). Jürgensen et al. (2010) looked at friendship development among German intersex students, finding they tended to befriend both boys and girls at school, whilst endosex students privileged same-sex friendships.

Methodology and method

This study's design was informed by constructivist grounded theory, an approach which allows for the exploration of issues on which there is little existing research (Grbich 2007). We sought to provide a platform on which participants could directly tell their stories, establishing the basis for future work (Huberman and Miles 2002). Constructivist grounded theory is underpinned by a relativist ontology, which presupposes the existence of multiple social realities in line with post-modern thinking (Charmaz and Bryant 2011; Kenny and Fourie 2015).

Such an approach centres participants' and researchers' co-constructions of knowledge and the mutual interpretation of meaning towards the interpretive depiction of participants' experiences (Kenny and Fourie 2015). In this study, this approach foregrounded people with intersex variations' experiences through the use of an intersex studies lens (Jones 2018). Prioritising individual narratives allows for a deeper understanding of lived experience. It also disrupts the traditional psycho-medical theorising that can occur in research on people with intersex variations conducted using a more formal institutionalised approach.

Data were collected by means of an online survey hosted by SurveyMonkey. The survey instrument used closed (quantitative) questions to gather demographic data. Open-ended (qualitative) questions were also asked about experiences from infancy to adulthood to enable story-focussed chronological theorising (Charmaz and Bryant 2011; Huberman and Miles 2002; Kenny and Fourie 2015). The questionnaire used was piloted with two people with intersex variations to ensure sensitivity and practical coherence.

Recruitment targeted self-selected English-speaking participants aged 18 years and over, with medically recognised intersex diagnoses or traits. Online advertisements, international support organisation newsletters and webpages were used to recruit participants over an eleven-month period in 2015.

Constructivist coding guidelines advocate the imaginative interaction with data using 'at least two stages' of coding: initial/open coding and re/focused coding phases, both of which were used in this study. The openness of this approach insists on a willingness to 'tolerate ambiguity' (i.e. to 'not know') so as to be open to the creation of new categories (Charmaz 2006; Charmaz and Bryant 2011; Kenny and Fourie 2015). With reference to the chief concerns of participants, selected words and phrases were turned into initial coding categories using gerunds such as 'experiencing', 'revealing', 'questioning' and 'desiring' so as to establish the 'what', 'how' and 'when' of these concerns. Memo writing was then used to compare these categories against data from other participant statements to test the validity, cohesion and usefulness of the coding frame. Once this has been completed, the process moved to a phase of theoretical sampling (Chun Tie, Birks, and Francis 2019) or focused coding (Charmaz and Bryant 2011).

This sought to examine and reorganise the initial data by identifying significant and/or recurring codes that carry the weight of the analysis, gain traction and generate 'analytic

momentum' giving rise to larger, more abstract concepts (or emergent categories) and labels which allowed theory to develop (Charmaz 2008). Once established, significant codes were identified as provisional theoretical categories for 'theoretical sampling'; the consideration and testing of all theoretical connections in the data using an 'abductive logic'. Further memo-ing then took place to identifying patterns relating to these key concerns, including determining conditions, progression and consequences, until theoretical saturation was reached. This resulted in a conceptual understanding (as opposed to an explanation) of the studied social processes, interwoven as a narrative or story encompassing key categories, conditions, relationships and consequences (Hallberg and Lillemor 2006; Kenny and Fourie 2015).

The study was approved by the Human Research Ethics Committee of the University of Sydney (project number 2014/225).

Findings

Sex and gender

The study adhered to key ethical considerations for intersex research (Jones et al. 2016) by granting a degree of control and freedom to participants by permitting them to opt out at any time and by keeping all questions optional. A total of 86 participants were included in the analysis. They varied between 22 and 71 years of age with a mean of 43 years. Participants came from North America (n = 47), Europe (n = 20), Asia-Pacific (12) and Africa (n = 1). Collectively, they were born in 19 countries but at the time of data collection most were in North America (n = 38), the UK (n = 10), Canada (n = 9) and Australia (n = 8). The majority (43) of participants had been assigned-female/F-at-birth (AFAB) and 31 had been assigned-male/M-at-birth (AMAB). The remaining participants (n = 3) had been assigned multiple times during infancy, or had not been assigned and a few opted not to disclose (n = 3).

When asked about gender identity 60 participants responded. Thirty-one of them identified as women; nine added details like 'female probably', 'ambiguous female', 'butch female' and 'agender/female'. A smaller number of participants (n = 10) identified as male: 1 added 'male of centre, but I prefer to opt out of gender descriptors'. Other participants challenged biological category and social role assignment based on a two-sex/gender binary model, identifying as intersex (n = 7), fluid (n = 3), no gender (n = 2) or using multiple identities subjectively (n = 7), one was 'fluid and playful'; another would 'dress in an androgynous attire and love having all the wrong sticky out body parts'.

The gender in which participants were brought up and gender affirmation

Of the 62 participants who answered both questions regarding assigned sex and gender identity, 58% (n = 21) of those who were assigned-female/F-at-birth (AFAB, n = 36) felt the gender in which they were brought up was appropriate. In contrast, only 23% (n = 6) of participants who were AMAB (n = 26) felt that the gender they were brought up with was appropriate. The finding that AMAB participants brought up as boys were more likely to claim that this gender was inappropriate was statistically significant ($p < 0.05$). When asked 'How do you feel about the gender you were raised [brought up with]?',

participants overwhelmingly responded that they did not fit traditional gender roles. Some spoke of struggling to fit in with other members of their sex and/or gender, or feeling like another gender altogether, making comments like 'I thought I was an 'it'' or '' … if I tried out for girls'' sports, I dominated them in a very masculine way, I was called a freak'. Some wished they had been brought up gender neutral. Others did not mind their sex having been assigned but desired greater choice of gender expression saying, for example, 'I think it is helpful to assign a gender at birth, but the ''door should be left open'' allowing the child to develop naturally'.

Participants felt influenced to enact particular forms of gender expression by their family and displayed negativity towards their parents. Eighteen indicated feeling shame, and nine anger. Three felt left out of identity processes, typically reflecting 'it was my body, but I couldn't choose anything'. Only three participants were happy with the gender in which they had been brought up. One participant said that being AMAB meant he could more easily identify with the gay male community. Another, who had been brought up gender neutral at home but not at school said, 'I picked my clothes from a certain age on, I picked if I wanted a haircut, I asked for my preferred toys. I just had to be a ''girl'' in public at school … '. Being involved in sex and gender decision-making processes and given agency to determine their expression and interests created a positive experience of being intersex. Another participant felt accepted within broader notions of how sex and gender relate: 'I tended to be somewhat of a tomboy growing up but that was treated as a normal and acceptable variation of being a girl'. Importantly, the three participants who were happiest with the gender they had been brought up with were encouraged to be themselves regardless of how they did or did not align with heterosexual binary sex-gender norms.

Participants who affirmed a different gender identity were asked, 'At what age did you begin to think that instead of being the gender you were raised [in], you should have been another gender?'. There were 38 responses to this question. 71% (n = 27) reported wanting to be a different gender under the age of 11 years, most commonly at about 3–5 years. When asked at what age did they firmly decide to affirm their gender, 12% (n = 5) affirmed their gender at 16–19 years and 37% (n = 15) at 20 years or older. Three participants had waited this long to affirm their gender identity out of fear or inner conflict: 'I fought with myself over it throughout my twenties, transitioned at 30'. Therefore, most firm decisions on gender affirmation were made later in life, despite discomfort being felt at an earlier age.

Navigating social isolation at primary/elementary school

Participants were asked about the impact of intersex status with respect to friendships at primary/elementary school. Of the 51 who responded, 30.7% (n = 16) stated their intersex status did not affect their primary/elementary school relationships, 30.7% (n = 16) felt isolated and 11.5% (n = 6) felt 'different' to their peers. Four had experienced bullying and three reported becoming depressed. Three participants reported they deliberately kept themselves to themselves and three described how they gravitated towards other 'social outcasts'.

Participants were asked the question, 'In primary/elementary school, how would you describe your feelings about your intersex variation? How did you experience and express these feelings? Explain'. Seven themes were identified from the analysed participant responses (n-50). Thirteen participants described feeling like a loner; a further five described feeling

extremely negative due to bullying. One of them commented, 'At each new school I was inevitably physically and verbally bullied. I remember my childhood as a miserable and defeated period of my life'. Four participants experienced depression and thoughts of suicide, including one assigned-female/F-at-birth (AFAB) participant who stated 'Anger was not allowed as a female. I was alone and very depressed … [I] tried to kill myself at 15 … I was not taken to a doctor or ER'. Four participants reported becoming aggressive towards others, three became withdrawn. Four felt unable to fit in with same-sex peers. Two felt they were pretending to be someone they were not. One AMAB participant reflected: 'Whenever I got called out for being effeminate or looking or acting girlish, I would try and act super masculine. I was terrified'.

Boys were sometimes pushed about or bullied by male peers (n = 3). One AMAB participant stated, 'All the boys wanted to do was call me sissy, faggot and bash the shit out of me'. Another outcast from the boys group sought refuge with girls:

> I generally did not conform well to male gender roles. I was often bullied and picked on for this. I did have a few friends, almost all girls and sometimes attended all girl sleepovers which made me feel accepted and comforted.

These statements suggest the importance of performing masculine behaviours in order to achieve acceptance by boys. Girls who mentioned not fitting in described not going through puberty like everyone else (n = 2) or being perceived as lesbian (n = 1). One of them stated:

> Things got progressively worse from age 10 to 14, as it was obvious something was odd/wrong since I wasn't going through puberty 'like the other girls'. I was constantly bullied over it and it reinforced people's belief that I would become a lesbian.

Four participants described stigma-based secrecy and a further three experienced shame about themselves, their body or their intersex variation. For example, one recalled feeling 'paranoid about people finding out [so I] kept to the [toilet] cubicles'.

Only five participants reported encountering no problems at primary school. One felt confident about their peers, one felt 'normal' and another felt their intersex status did not affect their school life.

Desired friendships in primary/elementary school

Participants were asked who they had been friends with during primary school. Those who responded to this question (n = 65) stated they had mostly sought friendship with girls only (n = 31), followed by both boys and girls (n = 20), and lastly boys only (n = 14). Overall, respondents mostly sought friendships with someone different to their assigned sex and gender (n = 18). Furthermore, those who had been brought up as boys were more likely to befriend girls (n = 12) compared to those who had been brought up as girls (n = 6).

Participants could select descriptors to subjectively describe their school friendships/perceived social status. Overall, 75% (n = 51) of participants reported having a below average numbers of friends. A cross-tabulation and chi-square test examined how many friends participants perceived themselves to have against the appropriateness of the gender in which they were brought up. More than half of the participants who perceived the gender in which they had been brought up was inappropriate reported having

Table 1. Appropriateness of the gender in which participants had been brought up and having an average number of friends (primary/elementary school) (n = 68).

Had about the average number of friends	Gender appropriate	Gender inappropriate	Pearson Chi-square	*df*
Yes	13	4		
Noa	17	34	9.623	1

ap < 0.02

a below average numbers of primary school friends ($p < 0.02$, see table 1), and increased bullying for being different ($p < 0.16$).

Participants were also asked to describe their experiences at school overall; responses mostly focussed on their feelings about peer relationships. Feelings of isolation were experienced by 15 participants, five of whom mentioned feeling like an outcast. Nine participants discussed feeling different, feeling alone or alienated. Four felt confused or frustrated about their gender identity or gender roles and expectations. One participant who had been brought up as a girl reflected, 'I wondered if I should have been born a boy, so I felt very alone'. Another described feeling frustrated that they had been treated like a boy, another had always felt at odds with the gender in which they were brought up and yet another described the difficulties of feeling transgender:

> I knew about trans and I figured that's what I was from a very early age (around 5) didn't know anything about my body just that it was strange, and I couldn't tell anyone. So, [I] kept very secret and tried to act normal, as in masculine.

Six participants experienced depression, captured in quotes such as: 'I felt alone and thought I must be some kind of alien. I became suicidal at age 13 and again at age 15'. One participant reported feeling they had been 'over-treated with psychiatric intervention' by two therapists, both of whom had misdiagnosed their childhood post-traumatic stress disorder arising from sexual abuse as generalised anxiety disorder. Another participant described concealing depression: 'I was very good at pretending to be happier and more outgoing than I was. I didn't show what I was going through on the inside'.

Four participants described being bullied at primary school. One said, 'I was teased for my gender non-conformity. It is not like I was walking around with my pants down. I also felt the whole picking [*sic*] order was strange and stupid'. Another stated that even though they were bullied, they had lots of friends. Of three participants who discussing not fitting in with their peers at primary school, one mentioned not fitting in with their same-sex classmates at school. Another, however, described not fitting in as an advantage, ' … as I was navigating who and what I was [*sic*], it made me realise I didn't fit in anywhere, which allowed me to fit in everywhere'.

Navigating social isolation in high/secondary school

Questions for primary school were repeated for high school attendance to allow comparisons, but were expanded to include questions about dating. Analysis revealed that the question 'In high school, how would you describe your feelings about your intersex variation?' elicited nine themes relating to feeling 'othered'. Common responses were depression, being bullied, pretending to fit in, secrecy and shame, aggression/anger, and avoiding school or school

activities. 14 participants described themselves as loners at high school. One said, 'I did my best to stay away from most people, keeping to myself as much as possible'. Half of the participants who were self-described loners also experienced feeling depressed or having suicidal thoughts. One said, 'I was often depressed and spent most of my time with girls even though most people didn't see me as a girl'.

Eight participants had experienced bullying at high school; four due to not conforming to dominant gender expectations or heteronormativity, including one who said, 'I was bullied and teased about being gay and fem, high school was hell'. Another explained, 'I went to a conservative Catholic high school. You did not express feelings of difference without risk. If you were gay you stayed in a hole in the ground,' Table 2 shows the relationship between reared gender appropriateness and being teased in high school. Eight participants engaged in behaviours to fit in with their peers – feigning interest in particular gendered acts or traits to gain approval. Two AFAB participants discussed having had 'lots of sex' to 'prove' their femininity: one described 'wearing the highest heels with the shortest skirt; having sex with boys starting at age 15', the other 'playing the role of a good girl'. As in primary/elementary school, boys described defending masculinity (or being bullied for a lack of it). One participant enjoyed experimenting with gender despite some stigma, secrecy and guilt.

> My greatest experience in high school was when I went to a Halloween party dressed as a girl. . . . Many of the boys asked me to dance and for the first time I was popular. I also felt a bit guilty, but [sic]did allow two of the boys to kiss me. Yet it felt wrong as I knew I was not a girl or a boy.

Others attempted to connect with other outcasts or minorities, with varying levels of success. For example, one participant said they '. . . felt connected with LGBT students but still didn't feel like I really fit in or was relatable'. Another found belonging as 'I was active in theatre, where everyone was different'.

Stigma-based secrecy was mentioned by eight participants. Participants described repressing thoughts about their intersex body (n = 2), lying or avoiding questions about their body (n = 3), or had been told to keep their intersex status a secret (n = 3). One stated 'I had not started my periods and I felt like I had to keep it a secret'; another explained they ' . . . always felt like I had a secret and I was not 'real''. A further two mentioned feeling shame one reflecting how they

> Got bullied a lot, showered with my shorts on or when people would leave. Was the smallest of the boys, stood out as well for being from a different ethic *[sic]* group, being socially awkward, ashamed of my body, stayed in my bedroom most of my teenage years feeling really angry and dysphoria [*sic*].

Table 2. Relationship between the appropriateness of the gender in which participants had been brought up and being bullied for being different in high school.

	Value	*Df*	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.317[a]	1	.012		
Continuity Correction[b]	5.023	1	.025		
Likelihood Ratio	6.364	1	.012		
Fisher's Exact Test				.016	.012
Linear-by-Linear Association	6.224	1	.013		
N of Valid Cases	68				

a.0 cells (.0%) have expected count less than 5. The minimum expected count is 8.38.
b.Computed only for a 2 × 2 table

Five participants felt aggression: one 'lashed out' due to being bullied, two described expressing anger towards others, another turned the rage inwards, reflecting 'I did a lot of drugs and put cigarettes out on my body. I put myself in dangerous situations with dangerous people so that I would die. I wanted to die accidentally on purpose'. Another three participants described denial, for example: 'I was in total denial. I am not sure I even understood my condition very well'. Multiple students skipped school or school activities; four specifically described the difficulties of Physical Education (PE) classes where the strategies they employed to avoid communal showering/changing after sport included showering with shorts on, creating conflict with the teachers, or avoiding the class entirely. Only one participant reported that knowing they were intersex had no impact on their primary or high school sex-based social learning and experiences.

Desired friendships at high/secondary school

50 participants (73% of those responding to the question) reported having a below average numbers of friends at high school, with those who felt the gender they had been brought up was inappropriate, being over-represented in this group.

In the context of romantic and sexual relationship formation during high school, the complexities of sexuality and gender identity were discussed by 17 participants. Four participants described not dating; one had no interest in romantic or sexual relationships; one questioned why it was so easy for others to form such relationships compared to themself; and two were too uncomfortable with the idea, citing being 'too body conscious' and 'too confused'. Other participants described same-sex attraction or non-heteronormative sexuality: one lesbian was out to friends, another feared disclosure, another embraced their individual sexual relations to others 'Women were always curious if because they liked me were [sic] they gay or straight, to which I would reply; 'Neither, you just like me!". Two participants discussed being popular with another sex: 'I felt lonely at times. I was very tall. But I felt people thought I was attractive and asked me out'. Participants of varying genders feigned gender conformity by engaging in heteronormative sex. One of them said, '[since] any "feminine" activities or behaviours drew negative attention. I had to pretend to be overly masculine in order to maintain relationships'. Two participants talked about feeling severely depressed by gender dysphoria and another felt confused about gender.

Eleven participants did report having close friendships at high school. For two of them, the number of friends had increased since primary school. Two others discussed how befriending other outcasts proved a good way to make new friends. One said, '[I] had a few friends who were also ostracised dorks. We banded together'. Whilst this participant was content with few friendships and nonconformity, others 'played a lot of sports and started drinking and using marijuana to help cope and to become "more popular"'. One participant remembered spending 'more time at home than what was normal' and another desired to escape: 'as an outsider, I escaped reading books and keeping to myself. It became more obvious in my teens that I wasn't a "normal" girl'.

Experiencing delayed/lack of puberty during high school was discussed by six participants One experienced bullying due to delayed puberty while another mentioned feeling ' more normal' compared to their peers who were going through puberty. One participant described

how hormone replacement therapy (HRT) had increased their isolation, because 'I did not understand the changes my peers were going through, why was I not experiencing them'.

Five participants reported no mental health concerns or difficulties with relationships during high school, but four experienced feelings of anger, using sport as an outlet for aggression, reacting violently to bullying, and simply feeling angry. Eight participants discussed an intensification of bullying in high school for reasons such as developing later or differently to endosex teenagers. One of them said, 'I was bullied for not developing breasts, for growing sideburns and a moustache, etc. People equated it to sexual orientation, and I was on the receiving end of much humiliation, speculation, etc'.

Eight participants described experiencing depression during high school. Two connected this to a lack of friends; two to gender dysphoria; two to suicidality and feeling withdrawn, numb and defeated. One participant reflected, 'I pretended to be a normal, happy girl [but] I was really very depressed and felt like I didn't fit in anywhere'. Six participants described disclosing their intersex status to friends. Three chose not to; one of them simply stated, 'I did not know how to talk about being intersex, so I did not disclose to anyone'. Others chose to disclose their intersex status with sometimes undesired results: 'I disclosed my intersex variation to my closest friends from primary school towards the end of high school and they drifted away in the following months'. Developmental sex and sexuality differences, therefore, amplified the barriers to developing social relationships for intersex high school students, whose strategic outreach to others was often hindered by a lack of support from schools, family and peers in framing intersex variations affirmatively.

Dating and sex

Of the 68 participants who answered a question about dating, 83% stated they did not feel comfortable dating during adolescence and 61% had not been sexually active as teenagers. Some participants described having other interests and priorities. For example, one said, 'I had no dates in my teens. I threw myself into sport and had no sexual awareness'. Other participants actively avoided romantic or sexual relationships due to being intersex, making comments like, '[I] dated a couple of times, kissed and cuddled, but nothing sexual, I was too scared she would find out I wasn't really a boy'. Three participants avoided sex because of their sexual orientation. One woman stated, 'There was no way I was going to be open to a boyfriend or be sexually active. I was also attracted to girls which confused me more about my sex of rearing and sexual orientation'. Six participants expressed no interest in sex at all, with one of them describing how this led to homophobic ridicule: 'My sister insisted that I was a homosexual because I showed no interest in sex'.

Thirty-nine percent of participants (n = 26) were sexually active as teenagers. Seven of them, however, said surgery made their experience of sex painful or less pleasurable. One AFAB woman said, 'I was sexually active after vaginoplasty, but didn't tell my male partners. It was very painful'. Three participants used sex to affirm or gain some control over their gender and social identity. One of them said:

> I had heard a certain guy was fairly small in size and knew I had a small vagina. Even though I had no interest in him whatsoever and he actually repulsed me, I felt I had to get this milestone over with to be considered a real girl and not a fake being.

This same participant continued to experience low self-esteem about being intersex, using sex to replace relationships in her late teenage years and early twenties, 'I started sleeping with anyone who would have me, certain that no one would ever want a relationship with me and that one night stands were the best I could hope for'. Another participant described how she had 'started having sex at 15 in order TO TRY TO [*sic*] feel comfortable as a girl and to prove to them and to me that I REALLY [*sic*] was a girl'. Another AFAB participant explained that for her, 'Sex was validation and control over others. I didn't actually have sex that was good and non-dissociative until decades later, after I transitioned and got new partners who wanted me the way that I actually was'. Across the sample, participants described learning as adults that positive relationships derived from building trust over time and sometimes, exposure to alternative communities that placed value on bodily diversity.

Conclusion

This paper has explored experiences of schooling among people with intersex variations with a focus on sex-based relational socialisation. Both in the way, they were brought up within their assigned gender role, and in their experiences at primary school, students with intersex variations generally learned they did not necessarily fit in with people of the same sex and/or that 'same-sex' was a concept it was hard to define. Consequently, their friendship formation and sense of self, more generally, went against the grain of other children's relational norms – increasing isolation.

In high school, some students with intersex variations learned to overplay or avoid engaging in the gender behaviours necessary to maintain 'normative' same-sex friendships, thereby mitigating the risk of exclusion, isolation or bullying. Others became part of alternative friendship groups (e.g. hanging with outcasts and minorities). High school students with intersex variations learned that dating and sexual relationships based on a two-sex binary model would likely exclude them. Their bodies and desires were not reflected in school-based puberty or sex education. More affirming alternatives did become available to some participants in adulthood, however.

Finally, data from this study suggest that difficulties socially navigating intersex experience in school may worsen for individuals who are not, as young people, given an adequate say in sex assignment, gender identity development and/or expression. Educational institutions should encourage the agentic involvement of intersex young people in decision-making to facilitate relationship formation. Efforts to enhance school-based inclusion through a focus on diverse bodies and friendship formation irrespective of sex and gender could be fruitful. In time, this may lead to a break down in stigma giving rise to intersex school-based exclusion and the development of socially isolated lifestyles.

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